## - Prescription Medication Only PARENT/GUARDIAN MEDICATION CONSENT FORM WITH PHYSICIAN'S ORDER FOR ADMINISTRATION

Student		Date				
School	Grade	Date of Birth		Age		
Physician Name	Phone					
Hospital/Clinic/Office						
<b>PHYSICIAN:</b> In order for school percomplete the following form. Please should any questions arise.						
Name and Dose of Medication	Tablet, Capsule, Pill, Other	Number to be taken	Approximate Time of Day	Term Short/Long	Self Carry (yes or no)	
*						
Name of medication and side effects						
Please indicate if the medication abo  Conditions under which PRN medicat  (Signature of physician)	ion should be given	are				
PARENT/GUARDIAN: (Please fill o return this form to the school office.		e form, after you	ur child's physicia	an has complete	ed the top, and	
I hereby give my permission to scho according to the written instructions the school principal/designee to cont	of the physician as	shown above. I				
Staff members can be informed about care.	ut the student's hea	lth concerns in o	order for the stud	lent to receive a	appropriate	
I further agree to hold the Two River from the administration of this media request or when any change in the a be in duplicate, labeled pharmac	cation at school. I a bove is necessary.	gree to notify th	e school in writir	ng at the termin	ation of this	
		_ Phone		Date		
(Signature of parent/legal guardian)						
Address						