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

Student ______________________________ Date ______________________________

School ____________________ Grade ________ Date of Birth ______________ Age __________

Physician ______________________________ Hospital/Clinic/Office ______________________________

Physician's Phone ______________________________

PHYSICIAN:
In order for school personnel to administer the medication regime you have prescribed, please complete the following form. Please feel free to call you child's school to initiate a contact with the school nurse should any questions arise.

Name and Dose of Medication	Tablet, Capsule, Pill, Other	Number to be taken	Approximate Time of Day	Term Short/Long

Name of medication and side effects ______________________________

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Please indicate if the medication above is PRN medication ______________________________

Conditions under whish PRN medication should be given are ______________________________

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Physician's Signature ______________________________ Date ______________________________

PARENT/GUARDIAN:
(Please fill out this portion of the form, after your child's physician has completed the top, and return this form to the school office.)

I hereby give my permission to school personnel designated by the school principal to give medication to my child according to the written instructions of the physician as shown above. I also hereby agree to give my permission to the school principal/designee to contact the child's physician.

Staff members can be informed about the student's health concern in order for the student to receive appropriate care.

I further agree to hold the Two Rivers Public School District and all employees harmless in any and all claims arising from the administration of this medication at school.

I agree to notify the school in writing at the termination of this request or when any change in the above is necessary. **(Please note any medication brought to school should be in duplicate, labeled pharmacy containers.)**

______________________________ Phone ________________ Date ____________
(Signature of parent/legal Guardian)

Address ______________________________