



## PARENT/GUARDIAN MEDICATION CONSENT FORM

(Please print or type)

Full Name of Child: \_\_\_\_\_

Name of Drug: \_\_\_\_\_

Dosage: (do not state as directed on package, write out directions to follow) \_\_\_\_\_

\_\_\_\_\_

Time to be given: \_\_\_\_\_ Number of days \_\_\_\_\_

Name of physician prescribing medication \_\_\_\_\_  
(if applicable)

Physician phone number: \_\_\_\_\_

Names of person(s) authorized to administer medication:

Mrs. Suzanne Holzhauer, Mrs. Cheryl Sanford or Health Room Volunteer

I hereby give permission to the above named persons to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold the school, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication.

I agree to notify the school in writing at the termination of this request or when any change in the above order is necessary.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date