Independence Public School

PARENT/GUARDIAN CONSENT FORM TO ADMINISTER MEDICATION

STUDENT'S NAME ______________________________ DATE OF BIRTH______________

MEDICATION_________________________ DOSAGE____________TIME TO BE TAKEN______

DATES TO BE TAKEN________________________ STUDENT'S PHYSICIAN______________

Condition/Circumstance for which medication is to be taken__________________________________

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Note: This parent consent form and the physician's order form (below), signed by the doctor, are required for prescription medication. For non-prescription, however, only the parent consent form is required.

- ✧ I hereby grant permission for my daughter/son to take medication at school, as ordered, and authorize school personnel to contact my child's physician if necessary.
- ✧ I agree to provide the school with the medication in its original, properly-labeled container.
- ✧ I agree to notify the school, in writing at the termination of this request or when any change in medication is necessary.
- ✧ I agree to release the Independence School District from any and all liability claims arising from the administering of this medication at school.

PARENT/GUARDIAN SIGNATURE______________________________________

DATE____________________________

PHYSICIAN ORDER FOR MEDICATION AT SCHOOL

STUDENT'S NAME______________________________

MEDICATION_____________________ DOSAGE______________ TIME TO BE TAKEN_____

START DATE______________________ STOP DATE______________________

Condition for which medication is to be taken____

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I hereby grant the school permission to administer this medication. Please contact me if the following symptoms occur:____

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PHYSICIAN'S NAME (Print)____

PHYSICIAN'S SIGNATURE__________________________________ DATE__________

CLINIC TELEPHONE NUMBER________________________