PARENT/GUARDIAN MEDICATION CONSENT FORM
WITH PHYSICIAN'S ORDER FOR ADMINISTRATION

Student _____ Date _____

School _____ Grade_____ Date of Birth_____ Age _____

Physician _____ Hospital/Clinic/Office _____

_____

PHYSICIAN

In order for school personnel to administer the medication regime you have prescribed, please complete the following form.

Please feel free to contact the Manitowoc County Public Health Nurses at 683-4155 should any questions arise.

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

Name of Medication and Side Effects:

_____

_____

_____

_____

Please indicate if medication above is PRN medication _____

Conditions under which PRN medication should be given are: _____

_____

_____

Physician 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.
- I further agree to hold St. Francis of Assisi School 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 CONTAINER.)

_____ Address _____

(Signature of Parent/Legal Guardian) _____

Phone _____ Date _____