Guadalupe CENTER

MEDICATION CONSENT

AUTHORIZATION FOR STAFF TO ADMINISTER OR SELF-ADMINISTER AL SCHOOL

Student Name_____ DOB_____ Age_____ Grade_____
Parent Name_____ Address/State/City: _____
Zip_____ Phone _____ School: _____

☐ I hereby authorize school staff to administer the medication described below to my child. I understand that a teacher or school personnel will administer only the medication(s) listed below. If there is any change in the prescription, a new parent consent form must be filled out by parent and physician in order to administer the new medication.

☐ I authorize my child to carry and have possession of his or her medication and may self-administer.

☐ I DO NOT authorize my child to carry and self-administer his or her medication. Please keep medication with school personnel.

MEDICATION MUST BE BROUGHT TO SCHOOL BY PARENT

My child and I understand there are serious consequences, in which include suspension for sharing medication with others.

Parent/Guardian Signature _____ Date _____

HEALTH CARE PROVIDER

AUTHORIZATION TO ADMINIUSTER OR SELF-ADMINISTER MEDICATON AT SCHOOL

NAME OF MEDICATION	INDICATION	DOSAGE	ROUTE	TIME
1.				
2.				
3.				
4.				

LICENSED HEALTH CARE PROVIDER STATEMENT

1. Name/Type of Medication_____
2. Dosage/ Amount Given:_____
3. Frequency/ times to be administer:_____
4. Duration (Week, Month, Indefinite, etc): _____
5. Anticipated reactions to medication (Symptoms, Side Effects for under dosage/ Overdose, etc):

_____
_____
_____
_____

Physician Signature: _____ Date: _____