

# Union County Public Schools Medication Consent Form

School: \_\_\_\_\_

Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Teacher/Grade \_\_\_\_\_

In order to help protect your child's health, your consent **and** written authorization from a health care provider with prescriptive authority is required when it is necessary for your child to receive prescription and/or non-prescription medicines.

**Parent or Guardian's Permission:** I give permission for my child to receive this medicine during school hours. I also give permission for school staff to contact the prescribing healthcare provider with questions/concerns. I understand that it is my responsibility to purchase and supply this medicine in its original container. On behalf of my child I absolve the Union County School Board and their agents and employees from any and all liability whatsoever that may result from my child taking this medicine at school.

\_\_\_\_\_  
Signature of parent or guardian      Date      Contact numbers (telephone, cell phone, pager, etc.)

This is used for emergencies only\*\*\*\*\***Both sides of this form are required for emergency self carry medications**\*\*\*\*\*

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**Below must be filled out by the Doctor/Health Care Provider:**

Medication \_\_\_\_\_ Strength/Dose \_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_

**Specific Directions** (include amount to give, at what time and/or how often, relationship to meals, specific indications if "as needed")

How often and/or at what time (hour): \_\_\_\_\_

Purpose of medication: \_\_\_\_\_

Relationship to meals, if applicable: \_\_\_\_\_

Expected side effects or adverse reactions: \_\_\_\_\_

Specific indications: \_\_\_\_\_

Other information: \_\_\_\_\_

It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. Please notify the principal and/or school nurse and parents/guardians if there are any problems.

\_\_\_\_\_  
Signature of Healthcare Provider      Date      Telephone      Fax

\_\_\_\_\_  
**Please print practitioner's last name      Practice name /address**

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**FOR SCHOOL USE ONLY:**

Date Received/By: \_\_\_\_\_ School Health Nurse Review: \_\_\_\_\_

Location of Medicine       on student, emergency medication only       in Health room       in Classroom