MEDICATION CONSENT FORM

Pioneer Elementary School

Name of Child: _____ Date of Birth: _____

School: _____ Grade: _____

DIAGNOSIS _____

NAME OF MEDICATION: _____

TIME: _____ DOSAGE: _____

BEGINNING DATE: _____ ENDING DATE: _____

POSSIBLE SIDE EFFECTS: _____

NAME OF PRESCRIBING HEALTH CARE PROVIDER: _____

I request that the trained designee allow my child to take, or administer my child the medication, as directed above. I authorize the release and exchange of health information from the above health care provider to RiverStone Health and the School. This consent is valid for the current school year. A health care provider's signature will be required for all prescription medication use (longer than two weeks, and as requested by the School Nurse).

Signature of Parent/Guardian Date Phone

_____

Emergency Name and Phone Number

Signature of Prescribing Health Care Provider Date Phone#/Fax#

PARENT NOTE:

Student medication MUST be in the prescription bottle or the original bottle for the over-the-counter medication. Refer to medication policy/procedure.