Medication Consent Form

Full Name of Child	
Name of Drug and Dosage	
Hour to be given	Name of Physician Ordering Drug
Phone Number	
Starting Date	Termination Date
Reason for Medication	
and to contact the child's physician if rabove person harmless in any and all cl	personnel to give the medication according to the directions stated above necessary. I further agree to hold the School District of Cameron and the laims from the administration of this medication at school. I agree to changes in the above orders are necessary.
Signature of Parent/Guardian	Date

*This Form must be returned to your child's school before school staff can administer medication!