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 _____

Specific Instructions _____

I hereby give my permission to school personnel to give the medication according to the directions stated above, and to contact the child's physician if necessary. I further agree to hold the School District of Cameron and the above person harmless in any and all claims from the administration of this medication at school. I agree to notify the school in writing when any 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!