SAUL MIROWITZ JEWISH COMMUNITY SCHOOL

MEDICATION CONSENT FORM

Please complete this form for all medication that is to be stored in the School office and administered by designated School Staff. This form must be accompanied with the medication to be administered.

This form is to be completed by the child's licensed health care provider who is prescribing the medication and signed by the health care provider and parent/guardian. Medication orders from the child's parent who is a licensed health care provider will not be accepted. **Medication MUST be in original container with dosing instructions.**

STUDENT'S NAME: ________________________________ **GRADE:** ____________

1. Medication: ______________________________ Dosage/Route: ______________

Time(s) of day: ________________ Start date: __________ End date: __________

Reason for Medication/Diagnosis: ____

Give medication for the following symptoms/complaints: ______________________

____

Side Effects/ Special Instructions: ____

2. Medication: ______________________________ Dosage/Route: ______________

Time(s) of day: ________________ Start date: __________ End date: __________

Reason for Medication/Diagnosis: ____

Give medication for the following symptoms/complaints: ______________________

____

Side Effects/ Special Instructions: ____

I hereby request and authorize designated School Staff to give the above named student the medication as specified on this form, according to the school medication policy. I acknowledge that the medication may be administered by a non-medical person.

______________________ ______________________ ____________
PRINT Health Care Provider Name **Health Care Provider Signature** **Date**

____
Health Care Provider Phone Number

______________________________ ____________
Parent/Guardian Signature **Date**

____
Parent/Guardian Phone Number