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 medication is to be used for emergencies only. Please allow this student to self-administer this medication

*******Both sides of this form are required for emergency self carry medications*******

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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