PARENT CONSENT AND PHYSICIAN ORDER
FOR ADMINISTRATION OF MEDICATION IN THE SCHOOL

PARENT CONSENT

I hereby request and give permission to the principal or his/her designee to supervise administration to my child _____ the medication and/or medical procedure _____ _____ as prescribed by Dr._____ in the stated order below.

I agree that the school will receive the medication in its original container and label. In the event medical supplies are required to perform a prescribed procedure I agree to provide them to the school in a labeled container.

Parent Signature_____ Date_____

Address_____

School_____ Grade _____

PHYSICIAN'S ORDER

(Note: All blanks must be completed)

STUDENT'S NAME_____ Date_____

I. **MEDICATION**_____

Route_____

Dosage_____

Time of Administration_____

Start Date_____ Stop Date_____

Adverse effects which should be reported to the physician_____

_____

Special instructions for administering medications and/or storage requirements_____

_____

II. **MEDICAL PROCEDURE** _____

_____

Time for procedure_____

Start Date_____ Stop Date_____

Special instructions for cleaning and storage of equipment and sterile requirements_____

_____

III. **PHYSICIAN'S NAME**_____

Physician's signature_____ Date_____

Business Address_____

Business Telephone Number_____