

**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 _____