MIAMI EAST LOCAL SCHOOL DISTRICT

PRESCRIPTION OR OVER THE COUNTER MEDICATION CONSENT FORM

Medications are to be administered at home whenever possible. If it is necessary for a student to receive medications at school, all blank portions of this form MUST be completed before medication can be given at school. One form for EACH medication is required.

Student
Name:_____School:_____Grade:_____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

Name of Medication:_____Date Start:_____ Date End:_____
Dosage:_____Frequency:_____Allergies:_____
Possible Side Effects:_____
If PRN, describe conditions under which to
administer:_____

**All medication must be in its original over-the-counter or prescription container labeled with the child's name

ASTHMA INHALERS ONLY:
Yes____ No____ This student and his/her parents/guardians have been instructed in self-administration and Student may carry inhaler and self-administer in school.

Physician's Name_____Address_____Phone_____
Physician/Practitioner Signature_____Date_____

PARENT/GUARDIAN CONSENT:
(Complete for all prescription and non-prescription medication/procedures at school)

* I request and authorize that this medication be administered at school, by school personnel.
* I will supply medication in its original, updated, properly labeled container.
* This order is in effect for this school year only.
* I will obtain a new physician's order and notify the school of any changes.
* I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
* I understand that when medication at school is no longer needed, an adult will pick up remaining medication. *It will NOT be sent home with the child.*
* I understand that all medication should be delivered to the school by parent/guardian.
* I understand that medication may be given by non-medically trained school personnel.
* I will make certain that my child takes responsibility for taking the medication as prescribed.
* I agree to hold the Miami East School District, its employees and agents who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.

The above medication is to be administered during the school day in accordance with the above instructions. I have read and understand this form and consent to the above.

Parent/Guardian Signature_____Date_____

Address_____Phone_____

Date received at school:_____/_____/____ Received by:_____

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