TITLE:
Consent for School to Administer Medication or Dietary Supplement to Student and Authorization for Release of Health Information

FORM: JHCD-R-F(1)

Updated 7/27/2020

PART A: Parent Request for School to Administer Medication (OTC or Prescribed) or Dietary Supplement

PART A must be completed for School to administer any medication (OTC or Prescribed) or Dietary Supplement to a student.

I request the School to give my child, ______________________________ this medication ____________________________
Student Name / Name of Medication

Time to be given: every _______ hours as needed or at ________ daily. Dates from _______________ to _______________

I acknowledge: (1) The School will not administer any medication for more than five consecutive school days unless the request is accompanied by PART B – Health Care Provider Order. (2) I must supply all medication in the original container and, if prescription medication, the container must have a label identifying the pharmacy, dose instructions, and issuing health care provider. (3) If a medication or dosage is changed, I will notify the School immediately and complete a new consent form. (4) The School will confiscate and take disciplinary action if the Student misuses medication, including unauthorized possession or self-administration. (5) If I have provided a completed PART B, I authorize the School to speak with my health care provider regarding my child's medication or dietary supplement. Medication not picked up by the end of the school year will be destroyed.

Parent or Guardian Name (Printed) ______________________ Parent or Guardian Signature ______________________

Date __________ Cell Phone or Best Contact # ______________________ Email ______________________

PART B: Health Care Provider Order for School to Administer Medication (OTC or Prescribed) or Dietary Supplement

Part B must be completed for School to administer medication (OTC or Prescribed) or Dietary Supplement to a student for more than five consecutive school days.

I request the following student be given medication at school because I believe there exists a valid health reason which necessitates medication administration during the school day.

Student Name ______________________ Birthdate ______________________

Medication ______________________ Time to be administered at School ______________________

Condition being treated ______________________ Dosage and mode of administration ______________________

Side effects to be expected, if any. (What emergency measures should be taken if this occurs?) ______________________

Other medications the School should be aware of ______________________

Health Care Provider Name (Printed) ______________________ Health Care Provider Signature ______________________

Address ______________________ Date ______________________

Telephone ______________________ Fax ______________________ Email ______________________