Immaculate Conception High School

MEDICATION CONSENT FORM

For all medication except Benadryl and Epinephrine for Life Threatening Allergies, Asthma Inhalers and Insulin

Student's Name_____ **D.O.B.** _____

Parent/Caregiver's Name_____ **Date**_____

Telephone: Home_____ **Work**_____ **Cell**_____

PART 1- TO BE COMPLETED BY STUDENT'S PHYSICIAN OR DENTIST
One medication per consent form
PLEASE COMPLETE ALL SECTIONS THAT APPLY

A. MEDICATION ORDER

I certify that it is essential to the health of _____ that the following medication be administered by the school nurse during school hours as directed.

DIAGNOSIS: _____

NAME OF MEDICATION: _____

DOSAGE: _____

MODE OF ADMINISTRATION: _____

FREQUENCY OF ADMINISTRATION: _____

TIME OF ADMINISTRATION: _____

SIDE EFFECTS/PRECAUTIONS: _____

LENGTH OF TIME ORDER IS VALID (may not exceed school year):_____

B. MEDICATION SCHEDULE ADJUSTMENTS:

Instructions for administration of medication on an altered school day:

_____ MEDICATION MY BE OMITTED ON A CLASS TRIP

_____ ADMINISTER THE MEDICATION WHEN THE STUDENT RETURNS FROM CLASS TRIP

_____ PARENT WILL ADMINISTER MEDICATION TO HIS/HER CHILD WHILE ACCOMPANYING CLASS TRIP

CIRCLE ONE: ADMINISTER / DO NOT ADMINISTER MEDICATION ON EARLY CLOSING DAYS

CIRCLE ONE: ADMINISTER / DO NOT ADMINISTER MEDICATION ON DELAYED OPENING DAYS

SIGNATURE OF PHYSICIAN/ DENTIST_____ DATE_____

PHYSICIAN/ DENTIST STAMP_____ PHONE#_____

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PART 2- TO BE COMPLETED BY PARENT/CAREGIVER

A. Parent/Caregiver Permission for School Nurse Administration of Medication

I give permission for the school nurse to administer the medication described on the reverse side. I will notify the nurse immediately if this medication is no longer required.

I disclaim all liability of Immaculate Conception H.S. **as it concerns the use of this medication.**

I further understand that this permission is effective only for the school year for which it is granted. It must be renewed for each subsequent school year.

_____ _____

Parent/Caregiver Signature **Date**