- ❑ Stored in clinic
- ❑ Self-Carry
- ❑ Stored in Refrigerator

Emergency Contact#:_____
Allergies: _____

_____is to receive the following
(Student name- grade- teacher)

Medication at school(**one med per consent form**)_____

My child must receive this medication during school hours for the following reasons:
_____.

Possible side effects: _____.
Special instructions: _____.

Date to begin: _____ Date to end (stop): _____
Amount to be given: _____ How often: _____
Time to be given: _____

Parent/Guardian Name:(please print)_____
Parent/Guardian signature: _____Date: _____

- **All prescribed medication, to be administered at school, must be received in the original container.**
- **All prescribed medication to be administered at school, must be delivered to school and retrieved from school by the student's parent, legal guardian or another adult who presents written authorization from the student's parent or legal guardian.**
- **Over the counter medications will not be given without prior authorization from the school nurse.**

Date	Amount Dropped Off	Received By	Received From	Medication Expiration Date	Prescription Expiration Date

Name: _____ Initials: _____ Name: _____ Initials: _____

Name: _____ Initials: _____ Name: _____ Initials: _____

MEDICATION PICK UP/ DISCARD

1st ATTEMPT TO REACH FOR PICK UP	2nd ATTEMPT TO REACH FOR PICK UP	3rd ATTEMPT TO REACH FOR PICK UP	DATE OF PICK UP/DISCARD	AMOUNT PICKED UP/DISCARDED	PICKED UP BY	DISCARDED BY	WITNESSED BY

CONSENT FORM MUST BE COMPLETE

COMMENTS:

Date	#pills	Rec'd by	Rec'd from	Date	# pills	Rec'd by	Rec'd from

Revised 7/2022