## PARENTAL/GUARDIAN CONSENT FOR HANKINSON PUBLIC SCHOOLS

## TO PROVIDE MEDICATION

Student's Last Name: _____

Student's First Name: _____

Grade: _____ Gender: _____

Date of Birth: _____/_____/_____

**MEDICATION AUTHORIZATION**

NOTE: Fields marked with an (*) must be completed by a healthcare provider for **prescription medication.**

*Medication's Name: _____

*Diagnosis/Reason for Medication: _____

*Dosage: _____

*Time(s) of Day: _____

*Physician's Signature:_____Date:_____

Dates Medication must be provided at School:

_____Short Term: (List the dates to be given) _____

_____Everyday as directed by healthcare provider

Consent for self-administration by student (with approval of parent/guardian & school Medication Administrator) _____Yes _____No

**I am the parent or guardian of _____.**

**I give my permission for him/her to take the above-mentioned medication at school. I acknowledge that all medication must be brought to and stored in the school's office.**

**Parent/Guardian Signature: _____**

**Date: _____**