



Warren County Public Schools

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OFFICE OF THE
SUPERINTENDENT

Parent Consent for Prescribed and/or Over-the-Counter Medication Administration

I hereby authorize Warren County Public Schools and its designees to administer the following medication, as ordered, by my child's Physician and/or Dentist. By signing this form, I consent to the exchange of medical information between the ordering Physician/Dentist and Warren County Public Schools. I also release Warren County Public Schools from any injury that may occur from the administration of the prescribed medication. I understand that Warren County Public Schools will only administer over-the-counter medications according to the directions on the bottle; or prescribed medications as directed by the prescriber.

Parent Signature _____ Date _____

Physician's Name and Phone Number _____

Physician Order for Prescribed Medication Administration

Name of Student _____ D.O.B _____

Medication _____ Related Diagnosis _____

Dose _____ Time _____

Route _____ Physician Signature _____ Date _____

Over-The-Counter Medication Administration

Name of Student _____ D.O.B _____

Medication _____ Dose _____ Time _____

Route _____ Reason for administration _____

Parent Signature _____ Date _____