HICKMAN COUNTY SCHOOLS
MEDICATION CONSENT FORM

Medication shall be administered only when the student's health requires that it be given during school hours. It is the parent/guardian's responsibility to BRING the medication to school and remove any unused medication when treatment is completed.

All prescription medications must be brought to school in the original pharmacy container with the pharmacy label attached.

All non-prescription medications must be brought to school in the original manufacturer's labeled container with the ingredients listed and the child's name written on it.

No more than one month's supply of any medication should be brought to school.

MEDICATION INSTRUCTIONS

Student's Name	Date of Birth	School	Teacher/Grade

Name of Medication:_____ Dosage (amount) to be taken:_____

Route(orally, topically, inhalation, injection):_____ Time:_____

Reason medication is needed during school:_____

Date last dose should be given:_____ **OR** check here____ if needed throughout year

Pharmacy Name_____ Pharmacy Phone Number_____

PHYSICIAN AUTHORIZATION

The above named student is under my medical supervision and needs to take the listed medication during school hours.

Printed name of Provider	Signature of Provider	Phone number	Date

PARENT/GUARDIAN AUTHORIZATION

I request for my son/daughter to self-administer this medication with assistance from school staff and I declare that he/she is competent to do so. I will assume full responsibility for any side effects and complications my child may have as a result of taking this medication. I give permission for the health care provider and/or pharmacy to release information or documentation regarding this medication record to the Hickman County School System if needed. The information may be faxed, mailed, or spoken of in person or by telephone conversation.

Parent/Guardian Signature	Home/Work/Cell Number	Date