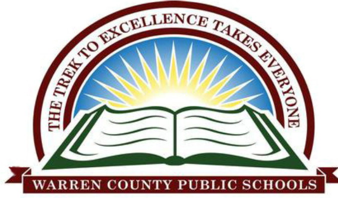

Parent Consent for Prescribed and/or Over-the-Counter Medication Administration

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 _________________________________

**** If an over-the-counter medication is given as a scheduled medication and is to be given for more than three (3) consecutive days at a time the Physicians Order for Prescribed Medication above needs to be filled out and signed by the prescriber.****