

Appendix A

Parental Consent for Medication Administration to their Child

Date: _____ School: _____

Student: _____ Grade: _____

My child is to receive _____ medication according to the physician's directions given for _____. This treatment will last _____. I give my permission for this medication to be dispensed to my child at school. My child has _____ drug allergies.

Signature: _____

Relationship to student: _____

Physician Consent for Medication Administration

Date: _____ Name of Student: _____

Medication: _____ Dose: _____

Time Interval: _____

Diagnosis or reason for treatment: _____

Side Effects to look for: _____

Restrictions: _____

Signature: _____

Appendix B
Record of Medication Administration

Name of Student: _____
 Medication: _____
 Date of Original Order: _____
 Date of Parental Consent: _____
 Comments: _____

School: _____
 Dosage/Time: _____
 Physician's Name: _____

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Aug																															
Sept																															
Oct																															
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Mar																															
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8-MAR

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

Codes: W=Weekend H=Holiday A=Absent F=Field Trip D=Early Dismissal DC=Discontinued DW=Dose Withheld O=No Show