Consent Form for Physician-Prescribed Medication

Physician's Order for Physician-Prescribed Medication

(Annual renewal required for students receiving ongoing medication)

1. Name of Pupil: _____ Birth Date: _____
2. Address: _____ City: _____ Zip: _____
3. Condition to be treated: _____
4. This is a list of all medications taken by this student: _____

   _____
5. Precautions, possible side effects, and recommended interventions: _____

   _____
6. **Check one:**

   ☐ I have reviewed and approved the standardized procedures as written on the reverse side.

   ☐ I have reviewed and approved the standardized procedures on the reverse side with my modifications.

   ☐ I have attached my recommendations for standardized procedures.

7. **IMPORTANT:**

   Name of medication to be taken during school hours: _____

   _____

   Time medication is to be taken during school hours: _____

   _____

8. I am aware that students self-administer medication in the Health office.
9. I will notify the school immediately if this medication/dosage is changed and will forward written confirmation thereof.

   A new consent form for any change in medication will be necessary.

(This consent form will have to be updated annually)

Physician's Name: _____ Telephone: _____

Address: _____ City: _____ Zip: _____

Physician's Signature: _____ Date: _____