

**DOWNE TOWNSHIP ELEMENTARY SCHOOL
MEDICATION CONSENT FORM**

School Year _____

If at all possible, parents are advised to give medication at home and on a schedule other than school hours. **IF IT IS NECESSARY** that a medication be given during school hours, these instructions must be followed:

1. Medication to be given must be brought to school in the original container with appropriate label intact. **Medication must be brought to the School Nurse's office at the beginning of the school day.**
2. Permission to dispense medication must be completed by prescribing physician/dentist.
3. Permission to administer medication must be completed by parent/guardian.

TO BE COMPLETED BY PHYSICIAN OR DENTIST

Name of Student _____ Date of Birth _____

Grade _____ Teacher _____

The School Nurse may administer the following medication(s) to the student named above. This has been prescribed by me to treat:

Name of medication(s) _____

Strength of medication(s) _____

Dose(s) to be given _____

Time(s) to be given _____ Duration _____

Side Effects _____ Restrictions _____

Check One: May miss dose on field trip Must have dose on field trip

Dentist/Physician Signature

Date

TO BE COMPLETED BY PARENT/GUARDIAN

The School Nurse at Downe Township Elementary School has my permission to administer the above medication to my child and has my permission to contact the physician or dentist as necessary.

Parent/Guardian Signature _____

Date

Telephone # _____

B929/14 revised