THE JOHN CROSLAND SCHOOL

MEDICATION CONSENT FORM

Student Name: _____ Birthdate: _____

In order to protect your child's health, The John Crosland School requires your written consent and the written authorization of your health care provider in order to dispense any prescription **or non-prescription** medications at school.

Parent or Guardian:

- I give the nurse permission to share with the appropriate school personnel information relative to the prescribed medication (such as side effects) as she/he determines necessary for my child's health and safety: ☐ Yes ☐ No
- If this medication is to be given at school, do you want it given on half days?
  ☐ Yes ☐ No

I understand that it is my responsibility to purchase and supply any medication to be dispensed at school in its original container. I give permission to the nurse or his/her designee to give the above named child this medication. On behalf of my child, I absolve The John Crosland School and their agents and employees from any and all liability whatsoever that may result from my child taking this medication at school.

_____

Signature of parent or guardian **Date** **Phone number**

Licensed Healthcare Provider Use Only: (please cross through any unused medication sections)

Name & Strength of Medication: _____
Time(s) to be given: _____
Route: ☐ Orally ☐ Inhaled ☐ Injected ☐ Other _____

Name & Strength of Medication: _____
Time(s) to be given: _____
Route: ☐ Orally ☐ Inhaled ☐ Injected ☐ Other _____

It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. Please notify the school nurse and parent/guardian if there are any problems.

THE JOHN CROSLAND SCHOOL MEDICATION CONSENT FORM (CONTINUED)

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Signature of Healthcare Provider   Date   Telephone   Fax

____
Please print Healthcare Provider's last name   Practice name & address

Licensed Healthcare Provider Use Only:

Name & Strength of Medication: ____
Time(s) to be given: ____
Route: ☐ Orally   ☐ Inhaled   ☐ Injected   ☐ Other ________________________

Name & Strength of Medication: ____
Time(s) to be given: ____
Route: ☐ Orally   ☐ Inhaled   ☐ Injected   ☐ Other ________________________

Name & Strength of Medication: ____
Time(s) to be given: ____
Route: ☐ Orally   ☐ Inhaled   ☐ Injected   ☐ Other ________________________

Name & Strength of Medication: ____
Time(s) to be given: ____
Route: ☐ Orally   ☐ Inhaled   ☐ Injected   ☐ Other ________________________

Name & Strength of Medication: ____
Time(s) to be given: ____
Route: ☐ Orally   ☐ Inhaled   ☐ Injected   ☐ Other ________________________

It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. Please notify the school nurse and parent/guardian if there are any problems.

____
Signature of Healthcare Provider   Date   Telephone   Fax

____
Please print Healthcare Provider's last name   Practice name & address