Louisburg School Health

Rockville Elementary	Broadmoor Elementary	LMS	LHS
PO Box 219	PO Box 367	PO Box 308	PO Box 399
Phone: 913.837.1970	Phone: 913.837.1900	Phone: 913.837.1800	Phone: 913.837.1720
Fax:913.837.1978	Fax: 913.837.1919	Fax: 913.837.1801	Fax: 913.837.1799

MEDICATION CONSENT FORM

FOR ALL MEDICATIONS PROVIDED BY PARENT/GUARDIAN & ADMINISTERED BY SCHOOL STAFF

OTC medications (over the counter) must be in the **original, sealed container** and will be administered only for what they are intended and within the normal dose.

Prescription medication must be sent in a **current, properly labeled prescription bottle**. When refilling the prescription, ask your pharmacist for a duplicate prescription bottle with current label that can be left at school. All changes in dosage require a new written order, and correctly labeled medication bottle.

Medication should be delivered to the nurse's office and picked up by the parent.

Student: _____DOB: _____Grade:_____

Medication Allergies: _____

Medication: _____ Route: (oral, topical, etc.) _____

Dosage:_____ Reason for medication:_____

Times to administer **AT SCHOOL:** (please be specific) _____

Date to start: _____ Duration for med to be given: (5 days, all year, etc.)_____

Required for prescription medication:

Physician Signature: _____ Phone: _____

Physician Name: (printed, please) _____ Date: _____

I give permission for student listed above to take the above medication at school as ordered. I understand that any school employee who administers any drug to my student shall not be liable for damages as a result of an adverse drug reaction suffered by the student because of administering such drug.

Signature of Parent or Guardian _____ Date: _____