Western School District

Consent Form for Prescribed Medication

Today's Date: _____

NOTE: THIS ENTIRE FORM MUST BE COMPLETED TO BE VALID

To Be Completed by Parent/Guardian:

Student Name: _____

Building: Bean Parma Warner Middle School High School Woodville

Teacher/ Grade: _____

I request that my child, _____, receive the medication listed below at school according to school policy.

Parent(s) signature: _____

To Be Completed by Physician, Physician Assistant, or Nurse Practitioner:

Name of Medication: _____

Reason for Medication: _____

Medication Form: (please circle one)

___Tablet/capsule ___Liquid ___Inhaler ___Nebulizer ___Other

Instructions (Schedule and dosage to be given while at school) _____

_____

_____Start Date _____Stop Date (This form expires the last day of school this school year)

Important Side Effects:

None anticipated: _____

Please list: _____

Storage requirements:

_____Needs refrigeration _____No special requirements _____Other

Physician's Name: (please print) _____

Physician's Phone Number (for questions):_____

Physician's Signature: _____