JOHNSTON PUBLIC SCHOOLS

MEDICATION CONSENT FORM

Student_____ Grade_____ Homeroom_____

I understand that special permission is required for the use of ANY medication during school hours and that medication may only be given by the School Nurse-Teacher. I request that my child be given the medication described below or be permitted to self-carry/self-medicate as authorized by me and my physician.

_____ _____ _____

(Parent/Guardian Signature) (Relationship) (Date)

This Section to be Completed By Physician

Name of Medication_____

Diagnosis/reason for medication _____

Dose_____ Route_____ Time to be Given_____

If medicine is to be given PRN, describe indications:_____

_____

Restrictions/Important side effects:

_____

Start: □Date form received Other date: _____

Stop: □End of school year Other date: _____

SPECIAL REQUIREMENTS:

For Inhalers and Epinephrine auto injectors:

- □ Student may self-carry medication
- □ Student may self-administer medication

For Field Trips:

- □ This medication may be omitted on field trip
- □ This student is capable to self-carry/self-administer this medication

NOTE: Please refer to procedure for students to self-carry/self-administer medication on field trips

Physician's Signature: _____ **Date:** _____

Physician's Name: _____

Address: _____

Phone: _____