



## ADMINISTRATION BUILDING

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### Consent for District Administered Medication Form 2023-2024 School Year

( A new form is required each school year for each medication)

#### Student Information

Student's Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

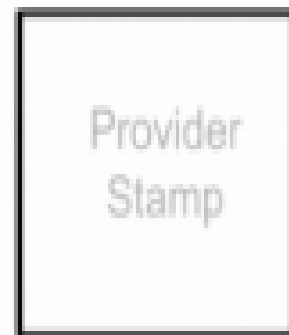
#### Healthcare Provider Information

**This section MUST be completed by the student's healthcare provider**

Name/Title: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_



#### Medication Information

Medication name \_\_\_\_\_ Dose: \_\_\_\_\_ Form of Medication \_\_\_\_\_

Reason For Medication: \_\_\_\_\_ Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Administration Method: \_\_\_\_\_ Administration Time/Frequency: \_\_\_\_\_

If \*as needed\* under what conditions is the medication to be administered: \_\_\_\_\_

Relevant Side Effects:

\_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Parent/Guardian Consent

I, \_\_\_\_\_, authorize school staff to administer medication accordance with this form and applicable policies. I acknowledge that Board Policy requires that I immediately inform the District of any changes to the healthcare provider's medication instructions.