Appendix A

Parental Consent for Medication Administration to their Child

Date: _____ School: _____

Student: _____ Grade: _____

My child is to receive _____medication according to the physician's direction given for _____. This treatment will last _____. I give my permission for this medication to be administered to my child at school. The school has my permission to call the physician with any questions regarding the medication.

My child has _____ drug allergies.

Signature: _____

Relationship to student: _____

Physician Consent for Medication Administration

Date: _____ Name of Student: _____

Medication: _____ Dose: _____

Time Interval: _____

Diagnosis or reason for treatment: _____

Side Effects to look for: _____

_____

Restrictions: _____

Signature: _____