

CATALINA FOOTHILLS SCHOOL DISTRICT

HEALTH SERVICES

AT-SCHOOL MEDICATION ADMINISTRATION CONSENT FORM

Student: _____ Grade ____ Teacher _____
Name of Medication: _____
Dosage: _____
Expiration Date: _____
Time to be Given: _____
Expected Duration of Treatment: From _____ To _____
Prescriber's Name: _____
Known Drug or Food Allergy: _____
Parent /Guardian Signature: _____ Date: _____

When it is essential to a student's health that medicine / prescription or over the counter (OTC) be taken during school hours

There must be a written order from a licensed health care provider stating the name of medication / OTC medication, dosage, and the time it is to be given. The parent consent form must be completed. Medication must be FDA approved.

- The medication must be in the original pharmacy or OTC container.
- Forms for students to carry and self-administer epinephrine auto-injectors and inhalers are available from the health office / cfsd website.
- Parents must hand deliver all prescription medication / OTC medication to the school health office.
- Supervision of medication administration protocol is managed by a registered nurse. In the nurse's absence medication will be administered by an agent/district employee designated by the principal; usually the health assistant or office secretary.
- Students may not carry medication on campus other than epinephrine, rescue inhalers, or diabetes supplies with written permission from a health care provider.

Physician Signature _____ **Print Physician Name** _____

Physician Phone _____ **Physician Fax** _____

PHYSICIAN SIGNATURE AUTHORIZES ADMINISTRATION OF THE ABOVE OTC PRESCRIPTION MEDICATION IN THE DOSAGE , ROUTE AND FREQUENCY INDICATED ABOVE BY SCHOOL NURSE OR DESIGNEE.

DATE MEDICATION Returned to parent	Amount returned	Parent Signature	RN/HA initials