Parental Consent for Medication Administration

HPS/Br. requires your signature and consent in order to be able to administer your child's medicine, so kindly take time to read and sign this consent.

Student name: _____ Grade and section: _____

Medication(s) details:

Name of Medication	Dosage	Time to be given	Days of the week medication to be given (please mark with X)				
			☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday
			☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday
			☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday
			☐ Sunday	☐ Monday	☐ Tuesday	☐ Wednesday	☐ Thursday

Any other instructions: _____

_____

I, Parent's name: _____, confirm that the above information is accurate. I agree and consent the school nurse to administer my child's medication(s) in accordance with the school policy. I also consent that I will inform the school, immediately and in writing, if there is any change in the medication(s), dosage or frequency of any of my child's medication(s).

Contact number of the parent: _____ Parent's signature: _____ Date: _____

Note: Medication(s) must be in the original container as dispensed by the pharmacy