



Carol S. Kress  
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## MEDICATION CONSENT

Name of Student: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Time: \_\_\_\_\_ Route: \_\_\_\_\_

Duration: \_\_\_\_\_

Possible side effects: \_\_\_\_\_

\_\_\_\_\_

Precautions/Restrictions: \_\_\_\_\_

Other medications taken: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

I hereby give my permission for \_\_\_\_\_ to receive from the school nurse or other trained school personnel, the above medication at school as ordered. I understand that it is my responsibility to furnish the school with this medication, I give permission for the school nurse and healthcare providers to the medical treatment facility to exchange information about my child, the diagnosis for which this medication is prescribed, and my child's response to the medication.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

Parent daytime phone number: #1 \_\_\_\_\_ #2 \_\_\_\_\_

\*Note: the prescription medication must be brought to school in the original container, properly labeled by the pharmacy or physician, stating the name of the student, the medication, the dosage and the current date. The medication will remain at school for the duration of the prescription.