JOINT SCHOOL DISTRICT NO. 2
1303 E. CENTRAL DR. MERIDIAN, IDAHO. PHONE (208) 888-6701

MEDICATION CONSENT FORM

Student's Name _____Age ____ Date of Birth _____

School _____ Grade _____ Teacher/Advisor _____

MEDICATION(S) taken **AT SCHOOL:**

Medication	Strength	Number taken	Time	Side Effects

When it is necessary for medication to be given during school hours, the following regulations must be followed:

1. Medication must be brought to school in the **original container with appropriate label intact.** Medication must be kept in a locked medicine area in the clinic or office. **IF MEDICATION IS NOT PROPERLY LABELED, IT WILL NOT BE GIVEN.**
2. Parent/guardian must sign this form granting permission for the nurse or nurse designee to administer medication.

The nurse or nurse designee has my permission to administer the above medication(s) to my child as prescribed by Dr. _____ for the purpose of treating _____. I give my permission for the School Nurse to contact the Physician/Dentist, if necessary regarding the medication(s).

_____ Student will be responsible for bringing his/her medication to school.

_____ Parent/Guardian will bring medication to school.

_____ _____ _____
Signature of Parent/Guardian Date Daytime Phone Number

Email address: _____

ADDITIONAL MEDICATION(S) taken **AT HOME:**

Name of Medication, dose, time taken

_____

_____