Shalom School

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www.shalomschool.org

Parent/Physician Medication Consent Form

All prescription and over-the-counter medication received must be:

1. Current and not expired
2. In its original container with a current prescription label (Ziploc bags, etc. are not acceptable)
3. Labeled with the child's first and last name on the container
4. Accompanied by a labeled dosage cup/spoon if medication is liquid

Please note: All prescription and over-the-counter medication will be administered by trained office staff/teacher and stored in the school office.

Parent Request (Physician's signature required on reverse page)

Child's Name _____ Birth date _____ Grade/Class_____
My child will need to take _____ (name of medication) at school.
He/she is to be given _____ (dosage) at _____ (time) with the following special instructions: _____
Beginning Date_____ Ending Date_____

___ Over-the-counter	_____ As Needed	___Short-term prescription

We, the undersigned, who are the parents of _____ (name of child) request that medicine be administered to said child by a designated member of the school staff, in accordance with instructions outlined above and signed by our physician (see reverse side).

We understand that the major responsibility for a child taking medication rests with the child and his/her parents. Furthermore, we understand that we are required to personally bring any and all medication to be administered to my child into the school office.

_____I authorize Shalom School to administer the medication named on the reverse side of this form in my absence as indicated by this form.

The following teachers/staff members were provided instructions/training and are allowed to administer medication: _____

Parent/Guardian Signature: _____ Date: _____

Physician Instructions:

Please note: Medical personnel are **not** available on the school campus. Whenever possible, please prescribe medication that can be given outside of the school day. If medication **must** be administered during school hours, please complete the following information:

*Parent must bring in the exact medication listed below.

Name of Medicine _____ Generic Name_____
Dosage _____ Route of Administration_____
Indications (Symptoms) _____
Dates/Times to be taken _____
Special Instructions/Precautions _____
Possible Side Effects _____
Actions to Be Taken in Event of Side Effects, Including Emergencies _____
Is the child able/trained to administer the medication by themselves with adult supervision? (Y/N)
Storage: ____ Refrigerated ____ Not Refrigerated ____ Other _____

Name of Medicine _____ Generic Name_____
Dosage _____ Route of Administration_____
Indications (Symptoms) _____
Dates/Times to be taken _____
Special Instructions/Precautions _____
Possible Side Effects _____
Actions to Be Taken in Event of Side Effects, Including Emergencies _____
Is the child able/trained to administer the medication by themselves with adult supervision? (Y/N)
Storage: ____ Refrigerated ____ Not Refrigerated ____ Other _____

____ *I authorize Shalom School to administer the above named medication as indicated by this form.*

OR

____ *I authorize Shalom School to administer the above named medication on an "**as needed**" basis during this school year.*

Prescribing Medical Provider Signature:

Signature: _____Date_____

Name: _____ Phone _____