LOCKWOOD SCHOOL MEDICATION CONSENT FORM

Name of Child: _____ Date of Birth: _____

Grade/Teacher: _____

DIAGNOSIS: _____

#1 MEDICATION: _____

DOSAGE: _____

TIME: _____

#2 MEDICATION: _____

DOSAGE: _____

TIME: _____

BEGINNING DATE: _____ ENDING DATE: _____

NAME OF PRESCRIBING HEALTH CARE PROVIDER: _____

I request that school personnel administer the above medication to my child at school as ordered. As per school policy, I will deliver the medication, in the pharmacy bottle to the school office. I authorize the release and exchange of health information from the above health care provider to Lockwood Schools. This consent is valid for the current school year.

_____

Signature of Parent/Guardian Date Phone

Printed Parent/Guardian Name: _____

_____

Signature of Prescribing Health Care Provider Date Phone#/Fax#