Aquinas High School/Middle School- Medication Consent/Authorization Form 2023-2024

Student Name:_____   Grade:_____

DOB:_____   Primary (Parent/Home) Phone#:_____

Over the Counter Medications							School shall contact the clinic for any of the following symptoms:	Other notes:
Medication Name:	Dosage	Route	Daily or As Needed	Time	Diagnosis/ Instructions/ Reason for Administration	Duration		
						From: To:		
						From: To:		
						From: To:		
						From: To:		

Prescription Medications							School shall contact the clinic for any of the following symptoms:	Emergency Medication Only. **Practitioner to initial box below if student is able to carry and self-administer**.ie Inhaler, Epinephrine.
Medication Name:	Dosage	Route	Daily or As Needed	Time	Diagnosis/ Instructions/ Reason for Administration	Duration		
						From: To:		
						From: To:		
						From: To:		
						From: To:		

PRACTITIONER INFORMATION (needed for all prescription medication administered at school):

Practitioner Name: _____   Phone: _____

Address: _____

The above prescriptions medications will need to be administered at school:

Practitioner's Signature:_____   Date: _____

Parent/Legal Guardian Consent (needed for all medication at school):
Medication will be provided by parent and in its original container or prescription labeled container.
I hereby give permission for school personnel to administer the above medication(s) to my child according to practitioner's and/or my instructions and authorize them to contact the practitioner if there is a question or concern. I further authorize the practitioner to render treatment to my child, as appropriate and necessary, arising out of administration of the medication.

_____   _____

Signature of Parent/Legal Guardian   Date

In the event that your child will have some unused doses of medication left at the end of the school year, please advise the school on how you would like the medication returned by completing the following:

☐ I will arrange to pick up the unused portion of my child's medication.

☐ Please send the unused portion of my child's medication home with him/her at the end of the school year.

I understand that I am responsible for making sure all medication arrives home safely.

Medication Consent/Authorization Form

Student Name:_____   Grade: _____

DOB:_____   Primary (Parent/Home) Phone#:_____

Staff- Please fill out completely for each dose.

MEDICATION GIVEN	DATE	TIME	INITIALS

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