Rockwood Area School District

Consent Form for Prescription Medication

We request that authorized school personnel administer this prescription medication to _____ according to the directions from our attending physician.
Student's Name

As parent/guardian of above named student, we hereby release the School District and all its employees from any and all liability for damages that our child may suffer as a result of this request.

Bottom part of form must be completed by physician.

_____ _____
Date Signature of Parent/Guardian

***All medication must be brought to the nurse's office or main office by a parent or adult_____**

Dear School Nurse:
It is essential that _____ receive the medication(s) during school hours as prescribed herein.
Student's Name

Name of medication (s) _____

Dosage/Route _____

Time to be Administered _____

Termination date _____

Purpose of medication _____

Possible side effects of contraindication _____

Curtailment of specific school activity _____
(sports, shop, lab, gym etc)
Other medication that student is taking outside of school hours_____

Is the student capable of self-administration and able to carry the medication on them at school as per school policy (inhalers/epi-pens only)? **Yes/No** Please circle one.

_____ _____
Date Physician's Signature

_____

Physician’s Telephone Number