NORTH CAPE SCHOOL DISTRICT
PRESCRIPTION MEDICATION
ADMINISTRATION CONSENT FORM
TO BE USED FOR UP TO 48 HOURS ONLY

Dear Parent/Guardian:

This form is only intended to be used on a temporary basis (maximum of 48 hours) while a physician's authorization is being secured for prescription medication.

To comply with our school's medication policy, please complete this form and return it to your child's school. This information will help us to be sure that the medication is given at the right time and in the proper dosage. **In order to comply with state regulations, the medication must be sent to school in its original container along with this completed form.** If this complete information is not provided, the school staff will not administer the medication.

If you have any questions, please contact your school. Thank you for your cooperation.

Date__________________________ School_____________________________________

Student Name____Grade____________

Name of Medication________________________________ Dose___________________

Days and Times of Administration____

Reason for Use____

Side Effects____

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I, the parent/guardian of the above named student, have read the school's medication policy and request the medication listed above to be administered to my child at school. I understand that qualified, designated person(s) will be administering the medication. I will notify the school immediately if there is a change or cancellation of the medication.

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Parent/Guardian Signature