(Refer to Policy IHCD, Procedure 4. b)

Student's Name: ______________________

Name of Medication: ______________________

Purpose of Medication: ______________________

Amount to be Administered: ______________________

Administration Time: ______________________

Possible Side Effects: ______________________

Storage Instructions: ______________________

Termination Date for Administration of Medication: ______________________

Student's Ability to Self-Administer:

I confirm that I have the authority to sign this consent and will inform any other parent or guardian of the contents of this consent and the fact it has been signed.

Parent/Guardian Signature: Date:

Doctor's note confirming above information must be attached (copy to Student Record.) OR the Doctor can sign this form:

Date Doctor's note verified: Refer to Policy IHCD Procedure 4. b)

The student's physician affirms that administration of medication to the student as requested by the parent is within the competence of an adult untrained in medical procedures.

Doctor's Signature: Date:

Notes:

- Contact parent if extra dose is required (i.e. student forgot to take morning dose at home).
- All medication should be kept in an appropriately secure manner.
- Principal must review and initial the Medication Administration Record on a regular basis.

MEDICATION ADMINISTRATION RECORD

DATE	DOSAGE	TIME ADMINISTERED	SIGNATURE