(Refer to Policy IHCD, Procedure 3. a)

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:

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

DATE	DOSAGE	TIME ADMINISTERED	SIGNATURE