Ottawa Area ISD
Sheldon Pines School

ADMINISTRATION OF MEDICATION CONSENT FORM

Sheldon Pines School

Medications (both prescription and over the counter) may be administered at school, by school personnel when necessary for school attendance. This completed form along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.

As a parent, I understand my responsibilities are:

1. To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy. (Parents may request that the pharmacist dispense two bottles of medication, one for home and one for school)
2. To provide the school with written doctor's instructions for medication administration during school hours.
3. To inform the school of any medication and/or medical changes.

Medication means: "any prescription or over the counter medication. This includes but is not limited to vitamins and food supplements; eye, ear, and nose drops; inhalants; medicated ointments or lotions; aspirins; cough drops; antacids."

Student: _____ Birthdate: _____ School Year: _____
Parent/Guardian Name: _____ Phone Number: _____
Physician's Name: _____ Physician's Phone: _____
Physician's Address: _____

I, _____ (parent/guardian name), _____ (relationship) to the student do hereby request that the building administrator or their designee, administer the prescribed medications listed below as directed and authorizes an exchange of information, as necessary, between the school and my student's health provider.

Parent/Guardian Signature: _____ Date: _____

Student (if an adult) Signature: _____

Physician should complete the following information:

Reason/Condition for the medication: _____
Name of Medication: _____
Form of Mediation: ☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other
Dosage: _____ Time **During** School: _____

Restrictions and/or side effects: ☒ None Anticipated ☐ Yes

Please describe restrictions and/or side effects:

Storage Requirements: ☒ None ☐ Refrigerate ☐ Other

This student is both capable and responsible for self-administering this medication: ☒ No ☐ Yes

Additional Information is: ☒ Attached ☐ Back of Form

Physician's Name (printed): _____ Date: _____

Physician's Signature: _____

Physician's Address: _____
Physician's Phone: _____ Physician's Fax: _____

A copy of this form will be kept in the student's CA-60 and will be renewed annually or whenever the prescription changes with the current school year.