**Howards Grove School District**
**Prescription Medication Consent Form**
**With Physician's Order for Administration**

Student _____ Date_____

School _____ Grade _____

Physican Name _____ Hospital/Clinic/Office_____

Physican's phone number _____

**Physican:**
The school district requires that all of the following information be provided before it will administer medication or treatment to the student named above.

Student's Diagnosis for Medication _____

| Name of Medication | Dosage (tsp., tablet) | Approximate Time of Dosage | Side Effects |
|---|---|---|---|
| | | | |
| | | | |

Please indicate if the medication above is PRN (to be taken as needed): _____

Conditions under which medication should be given: _____

_____

*Physician's Signature _____ Date _____

***Must Be Signed by the Physician**

**Parent/Guardian** (Please fill out this portion of the form after your child's physician has completed the top, and return this form to the school office along with the medication.)

I hereby give my permission to school personnel designated by the school principal to give medication to my child according to the written instructions of the physician as shown above.

I further agree to hold the Howards Grove School District and all employees harmless in any and all claims arising from the administration of this medication at school.

I agree to notify the school **in writing** at the termination of this request or when any change in the above is necessary. (Please note any medication brought to school needs to be in a labeled pharmacy container. Controlled substances must be transported by an adult. I will be responsible for bringing in medication when container becomes empty, otherwise no medication will be distributed.)

Signature of Parent/Legal Guardian _____

Phone _____