JOHNSTON PUBLIC SCHOOLS

MEDICATION CONSENT FORM

I. This section to be Completed by Parent/Guardian

Student_____Grade_____Homeroom_____

I understand that parental consent AND a doctor's order is required for the use of ANY medication during school hours, and that medication may only be given by the School Nurse-Teacher. I request that my child be given the medication ordered below or be permitted to self-carry/self-medicate as authorized by me and my child's physician.

_____ _____ _____

(Parent/Guardian Signature) (Relationship) (Date)

II. This Section to be Completed By Physician

Name of Medication: _____

Diagnosis/Reason for Medication: _____

Dosage: _____ Route: _____ Time to be Given: _____

If medicine is to be given PRN, describe indications: _____

_____

Start date:

- ❑ Date form received
- ❑ Other date:_____

Stop date:

- ❑ End of school year
- ❑ Other date:_____

Restrictions/Important side effects: _____

_____

SPECIAL REQUIREMENTS
For Inhalers and Epipens:
❑ Student may self-carry medication
❑ Student may self-administer medication
For Field Trips:
❑ This medication may be omitted on field trip
❑ This student is capable to self-carry/self-administer this medication

Date:_____ Physician's Signature:_____

Physician's Name: _____Physician's Phone: _____

(please print)