Alamogordo Public Schools
Health Services

MEDICATION CONSENT FORM

Name of Student_____

I give my permission for the school nurse to supervise the administration of the medication(s) prescribed by my doctor and listed below. I give consent for the registered nurse to consult the physician regarding these orders, if necessary, and I will be notified.

I understand that it is essential that the school nurse (registered nurse) be notified of all students taking medications at school. Because the school nurse is not always available to give the medications required by all children, the principal will authorize another school employee to supervise the actual administration of the medication in the absence of the registered nurse.

I understand that it is my responsibility to provide this medication in a container that is properly labeled. Prescription drugs will require original bottle/box with pharmacy label. Over the counter medications will require the original bottle with the label. I understand that it is my responsibility to bring the medication to the health office and pick up medications as needed/required.

_____
Parent/Guardian Signature
Date: _____

TO BE COMPLETED BY THE PHYSICIAN

It is necessary that _____receive the below listed medication(s).

MEDICATION	DOSAGE	TIME	REACTIONS

SPECIAL INSTRUCTIONS:

If the AM dose is missed, it may be given as needed, with parent/guardian consent
Student has been instructed on the proper use of an inhaler
Student's medical condition necessitates that they carry their medication(s) at all times.
Additional comments: _____

_____
Physician Signature
Date: _____
Telephone Number:_____

Office use Order/ computer / medication reviewed by school nurse: _____
Date reviewed: _____