SCHOOL DISTRICT OF ARGYLE

MEDICATION ADMINISTRATION CONSENT FORM

Student Name: _____ Grade/Teacher _____

Birth Date: _____ Allergies: _____

NOTE TO PARENTS/GUARDIANS:

The Argyle School District **REQUIRES** that students who need over-the-counter medication or prescription medication during school hours **MUST** do the following:

1. Present a written consent form signed by the parent or legal guardian for over-the counter medication or the physician if prescription medication is needed. (Consent form below).
2. Bring over-the-counter medication or prescription medication in the original container. Do not send medication in plastic baggies, envelopes or other unmarked containers.

NOTE: Many of the short-term medications do not need to be given at school. For example medications taken 3 times a day can be given before school in the morning, right after school and at bedtime.

CONSENT FOR OVER-THE-COUNTER MEDICATION

Medication: _____ Dosage: _____

Time to be given: _____ Reason for Medication to be given: _____

By signing below, I give school personnel permission to administer the above indicated non-prescription medication to my son/daughter. I understand that all medication should be in their original container. I give permission for necessary information related to my child's condition be shared with the school nurse.

_____ _____

Signature of Parent/Guardian Date

CONSENT FOR MEDICATION PRESCRIBED BY A PHYSICIAN

Medication: _____ Dosage: _____

Time to be given: _____ Reason for Medication to be given: _____

Precautions: _____

Other information to consider when administering this medication: _____

_____

_____ _____

Physician's Signature Date

By signing below, I give school personnel permission to administer the above indicated prescription medication to my son/daughter. I give permission for necessary information related to my child's condition be shared with the school nurse.

_____ _____

Signature of Parent/Guardian Date