Highland Community School

Medication Consent Form

Student Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

I am requesting that my child, _____, receive prescription or procedures at the time indicated and as designated by his/her medical provider.

I will be responsible for bringing the prescription drugs to school in a labeled container from the pharmacist. I also understand that I am responsible for maintaining a sufficient quantity of the medication or supplies for procedure at the school to avoid any interruptions in the physician's orders. Failure to do this will result in termination of the school's administration of the medication and/or procedure for my child. I understand that, if my child refuses to take the prescribed medication or allow the procedures, force will not be used by school personnel to make my child comply.

_____ _____ _____

Signature of Parent/Legal Guardian Relationship Date

Name of Medication (Generic & Trade Name)	Dosage	Specific Time (AM/PM)	Possible adverse side effects

The above medication orders shall be effective through _____ unless they are discontinued, changed by me, or withdrawn in writing by the parent/legal guardian.

_____ _____ _____

Physician's Signature Date Phone Number