



## PRESCRIPTION AND NON-PRESCRIPTION MEDICATION CONSENT

☐ Please check if NON-Prescription

I, the Parent/Guardian, hereby request and give my consent for the designated school staff member or administrator to see that my child, \_\_\_\_\_, receives the medication prescribed by (medical provider) \_\_\_\_\_ for Diagnosis/Condition \_\_\_\_\_.

The medication is to be furnished by me in the original labeled container, and given in the following manner:

1. Name of the medication \_\_\_\_\_
2. Strength of medication \_\_\_\_\_
3. Dosage (amount to be given) \_\_\_\_\_
4. Approximate time of administration \_\_\_\_\_ Don't give after (time) \_\_\_\_\_
5. Route of administration (by mouth, topically, etc.) \_\_\_\_\_
6. Date medication is to be discontinued \_\_\_\_\_

Healthcare Provider's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Healthcare Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Initial) \_\_\_\_\_ *I am aware that medications, except that pertain to life threatening conditions, WILL NOT be sent during a school designated field trip unless requested by parent at least 48 hours in advance of EACH field trip.*

(Initial) \_\_\_\_\_ *When deemed necessary, non-prescription medications will be administered with signed consent. Non-prescription medication given beyond 3 consecutive days, will need a medical provider's order to insure that this medication is not masking any underlying symptoms of a serious condition in the student.*

(Initial) \_\_\_\_\_ *I understand that I will be given notification regarding medication expiration. If no response is received or the medication is not replaced, this consent may be terminated by EDUPRIZE Health Office Staff and the medication discarded.*

(Initial) \_\_\_\_\_ *I understand that unless I have made previous arrangements with the EDUPRIZE Health Office Staff, any medication left in the Health Office after the last day of school, will be discarded.*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Teacher Name: \_\_\_\_\_ Grade: \_\_\_\_\_

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\*\*DO NOT WRITE BELOW THIS LINE – FOR OFFICE USE ONLY\*\*

Consent signed for dispense in building 2 or 3? ☐ Yes ☐ No Medication returned/discarded on (date) \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Self Carry: ☐ Yes ☐ No

EDUPRIZE Nurse Signature \_\_\_\_\_

Chamber/Spacer: ☐ Yes ☐ No