GENERAL MEDICATION ADMINISTRATION FORM

Student: _____Class of: _____DOB: _____

Medication:_____Dosage:_____Increment:_____

I AGREE TO THE FOLLOWING:
I consent to my child's medicine being stored and given at school based on directions from my child's health care practitioner. I also consent to any equipment needed for my child's medicine being stored and used at school.

I understand that I must give the school my child's medicine and equipment. All prescription medicine I give the school must be in the original bottle or box. I will Provide the school with current, unexpired medicine for my child's use during school days. Prescription medicine must have the original pharmacy label on the box or bottle.

Label must include the followings:

1) my child's name 2) name of medicine	3) my child's health care practitioner's name 4) date	5) Dosage number of refills 6) number of refills	7) when to take the medicine 8) how to take the medicine	9) pharmacy name and phone number 10) any other directions.

- **I must immediately tell the school about any change in my child's medicine or the healthcare practitioner's instructions.**
- **No student is allowed to carry or give him or herself controlled substances.**

Parent Signature_____Date_____/_____/_____