

PARENT CONSENT FORM

I Authorize the Principal/Designee of _____ School to administer

_____ to my child, _____
 (Name of Rx and dosage) (Name)

Grade/Teacher _____ at the time indicated below: (check which)

- 1) ____ Medication at _____ o'clock
- 2) ____ As necessary to control asthma or wheezing for which this medication was specifically prescribed, but no more often than every four hours.
- 3) ____ As necessary for _____

The medication shall be provided in a bottle showing the name of the pharmacy, student's name, physician's name, and the dosage of the medication to be given. I understand that the first dose of any medication must be given at home.

I absolve the school personnel of all responsibility for any unforeseen development or reaction attribute to the administration of the above-named medication. It is the responsibility of the child to come to the office to take his/her medication.

This authorization will terminate completely on _____
 (Specific Date)

 (Parent/ Guardian Signature) (Date of Authorization)

Date/Time/ Signature	Date/Time/ Signature
Signature Initials	Signature Initials
Signature Initials	Signature Initials

