School District of Monroe

CONSENT for PRESCRIPTION MEDICATION (for all schools)

Please complete both sections.

STUDENT NAME: ________________________________ **BIRTHDATE:** _________________________

GRADE: ___________________ **HOME ROOM:** ______________ **SCHOOL:** _____________________

* This form will need to be completed on an **annual** basis if your child receives daily medications at school.

FOR COMPLETION BY PHYSICIAN or HEALTH CARE PROVIDER

Medication **Dosage** **Time or Frequency**

____

____

____

Side Effects:____

Diagnosis Code for billing students with Medicaid and an IEP: _______________________

____

PHYSICIAN/ PROVIDER SIGNATURE: _______________________________ **DATE:** ________

Clinic Address: ____ Phone: ______________

FOR COMPLETION BY PARENT

❏ I give my permission to give the above medication(s) as directed and or communicate with the provider(s) if necessary.

I authorize trained staff to administer this medication at school and if the need arises the school nurse can communicate with the physician/health care provider as necessary regarding this medication. I authorize health personal under HIPPA and FERPA to communicate health information on a need to know basis. This allows for conversation with administration per district nurse and as necessary with teaching and support staff.

PARENT/GUARDIAN SIGNATURE: ___________________________________ **DATE:** ________

Home Phone: _________________________________ Work Phone: _______________________________

>Medication MUST be in the original prescription bottle.

>The label must be current with student's name, medication and date.

>Dosage changes require <u>written notice with provider and parent signature</u>.

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