Madison County School District

Consent Form for Administration of Medication

To: Parent/Guardian:

The Madison County School District requires that all students who require prescription or non-prescription medication(s) during school hours must do the following:

A. Present this written consent form signed by the parent/guardian and completed by a physician to the school office.
B. Parent/guardian must bring original prescription bottle, properly labeled by a legally registered pharmacist. Each school will have designated personnel who will be dispensing the medication(s) to your child.

MEDICATION(S) may be given by the designated school official **provided** that the prescribing physician completes the district medication permission request form. If there is a change in medication, please send a note to the school from the physician notifying the school of the change.

Name of Student _____ Date of Birth _____

School _____Teacher/grade_____

To Be Completed by Physician

Name of medication(s): _____

Specific time to be delivered _____

Dose to be delivered _____

Length of time each medication is to be administered _____

_____ _____

Printed Name of Physician Signature of Physician

_____

Date

****

To be completed by parent

I, _____give permission for my child _____ to receive the above medication(s) as written by a physician. I will not hold the Madison County School District, its employees and agents, liable for any injuries to my child or ward and for any damages or losses of any kind resulting from the administration to my child or ward of these medications.

_____

Parent Signature Date

This form does not require a notary seal. Revised 8/13/08