



Caldwell County Schools
MEDICATION CONSENT FORM

Student:	School:	Today's Date:
Date of Birth:	Home Phone:	Cell Phone:
Parent/Guardian:		

To be completed by your healthcare provider. Use a separate form for each medication.

Medication _____ Dosage/Route _____

Time (s) medication is to be given at school _____

Reason for medication _____

Side Effects / Precautions _____

START DATE _____ **STOP DATE** _____

Emergency Medications:

This student is capable and responsible to self-carry emergency medication (*please check below*)

(only for epi-pens, inhalers, insulin, emergency medications for seizures and diabetes)

- No Yes, with supervision
 Yes, Unsupervised- I have instructed the student in proper use/care of the medication.

X _____
Healthcare Provider Signature **Date** **Phone Number**

TO BE COMPLETED BY PARENT/GUARDIAN

I hereby give my permission for my child (named above) to receive the above medication at school. I assume full responsibility and will inform school staff of any changes for medication or health status. I hereby release Caldwell County School Board, their agents, and employees from any and all liability that may result from this medication administration. I agree to furnish medication in original, properly labeled pharmacy or store container.

Parent/Guardian Signature _____ **Date** _____