FREMONT PUBLIC SCHOOLS – MEDICATION CONSENT FORM

** This information expires on June 30, _______

Fremont Public Schools personnel are prohibited from providing or administering any medication to a student except as authorized by Board Policy.

If at all possible, parents are advised to give medication at home rather than during school hours. If it is necessary that a medication be given during school hours, the following regulations must be followed.

- The parent has completed the request for administration of medication and has furnished the school district with the completed physician's authorization and that information is on file at the school.
- **AUTHORIZATION MUST BE UPDATED ANNUALLY AND/OR FOR EACH NEW PRESCRIPTION**
- Medication must be brought to school by a parent/guardian in the original container with the appropriate label intact. Students may not carry medication to school or from school.
- **IF MEDICATION IS NOT PROPERLY LABELED, IT WILL NOT BE GIVEN.**
- The school <u>will not</u> divide pills in half.

I hereby give my permission to the Fremont Public Schools staff to administer the following medication to my child.

- **This entire form, including the signed physician's order if the medication is a prescription, must be complete and on file in the school building's office where that student attends.**

Child's name ____

School ________________ **Teacher/Homeroom** ______________________

Name of medication __________________ **Physician** ______________________

Dose to be given ____________________ **Time to be given** ________________

Reason for medication ____

Date to begin medication ______________ **Date to end medication** ___________

Parent/Guardian signature ______________________ **Date** ________________

**** PHYSICIAN MUST COMPLETE THE FOLLOWING <u>FOR ALL PRESCRIPTION</u> MEDICATIONS GIVEN AT SCHOOL.**

Child's name ____

Name of medication ____

Dosage __________________________ **Time to be given** ________________

Condition for which drug is being administered ___________________________

Relevant side effect to be observed, if any ______________________________

Special instructions (if any) ____

Date to begin medication ______________ **Date to end medication** ___________

Physician's phone number ____

Physician's signature __________________________ **Date** ________________

Revised April 2008