DISPENSING OF MEDICATION CONSENT FORM

Student _____ Date _____

School _____ Drug _____

Dosage _____ Pill Count _____

Prescribing Physician _____ Physician Phone _____

Time Interval _____ until _____
(date to discontinue medication)

I, parent/guardian of _____ ,
hereby give approval for the dispensing of medication to my son/daughter by school personnel.

Parent/Guardian signature: _____

Date	Time	Signature of Staff Member Dispensing Medication	Dosage/ Pill Count	Student Initial
			Pill Count	

(Form continued on reverse)

Student _____ Medication _____

Date	Time	Signature of Staff Member Dispensing Medication	Dosage	Student Initial
			Pill Count	
			Pill Count	

☐ Parent/Guardian signature on first page.