

MONTCLAIR PUBLIC SCHOOLS
MEDICATION CONSENT FORM

ONE MEDICATION PER CONSENT FORM PLEASE

For all medication except: Epinephrine for Life Threatening Allergies, Asthma Inhalers and Insulin

Student's Name _____ D.O.B. _____

Parent/Guardian's Name _____ Date _____

Telephone: Cell _____ Work _____ Home _____

PART 1- To be completed by student's Primary Healthcare Provider (MD, DO, APN) or Dentist

A. MEDICATION ORDER:

I certify that it is essential to the health of _____ that the following medication be administered by the school nurse during school hours as directed. This student will not be able to attend school or school sponsored events without this medication.

Diagnosis: _____

Purpose of Administration: _____

Name of Medication: _____

Dosage: _____ Mode of Administration: _____

Frequency of Administration: _____ Time of Administration: _____

Side Effects/Precautions: _____

Length of Time Order is Valid (may not exceed school year): _____

B. MEDICATION SCHEDULE ADJUSTMENTS:

Instructions for administration of medication on an altered school day:

_____ MEDICATION MAY BE OMITTED ON A CLASS TRIP

_____ ADMINISTER THE MEDICATION WHEN THE STUDENT RETURNS FROM CLASS TRIP

_____ ADMINISTER MEDICATION ON EARLY CLOSING DAYS

_____ DO NOT ADMINISTER MEDICATION ON DELAYED OPENING DAYS

Signature and Stamp of Primary Healthcare Provider (MD, DO, APN) or Dentist:

_____ PHONE# _____

*****GO TO NEXT PAGE*****

PART 2- To be completed by student's Parent/Guardian

Parent/Guardian Permission for School Nurse/Substitute School Nurse Administration of Medication

I give permission for the school nurse to administer the medication described on the reverse side.

I will notify the nurse immediately if this medication is no longer required.

I disclaim all liability of the Montclair Board of Education as it concerns the use of this medication.

I further understand that this permission is effective only for the school year for which it is granted.

All medication must be delivered to the school nurse by the parent/guardian.

All medication must be in the original pharmacy-labeled container with the prescription affixed or it will not be administered by the school nurse.

Any unused medication must be picked up by the student's parent/guardian. Medication not picked up by the last day of school will be discarded.

Parent/Guardian Name (please print) _____

Parent/Guardian Signature _____

Date

Revised 1/2017