Union County Public Schools Medication Consent Form

School: ____________________ **Telephone:** ____________________ **Fax:** ______________

Student Name: ______________________________________ **Birthdate:** _______________

Teacher/Grade: ____

In order to help protect your child's health, your consent **and** written authorization from a health care provider with prescriptive authority is required when it is necessary for your child to receive prescription and/or non-prescription medicines.

Parent or Guardian's Permission: I give permission for my child to receive this medicine during school hours. I also give permission for school staff to contact the prescribing healthcare provider with questions/concerns. I understand that it is my responsibility to purchase and supply this medicine in its original container. On behalf of my child I absolve the Union County School Board and their agents and employees from any and all liability whatsoever that may result from my child taking this medicine at school.

_______________________________ _________ __________________________________

Signature of parent or guardian **Date** **Contact numbers (home and cell phone)**

☐ **This is used for emergencies only***Both sides of this form are required for emergency self-carry medications******

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Below must be filled out by the Doctor/Health Care Provider:

Medication: ____ **Strength/Dose:** ______________________________

Medical Diagnosis: ____

Specific Directions **(include amount to give, at what time and/or how often, relationship to meals, specific indications if "as needed")**

How often and/or at what time (hour):____

Purpose of medication: ____

Relationship to meals, if applicable: ____

Expected side effects or adverse reactions: ____

Specific indications: ____

Other information: ____

It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. Please notify the principal and/or school nurse and parents/guardians if there are any problems.

_______________________________ _________ _______________ ________________

Signature of Healthcare Provider **Date** **Telephone** **Fax**

____ ____

Practitioner's Printed Name **Practice name /address**

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FOR SCHOOL USE ONLY:

Date Received/By: ____________________________________ School Health Nurse Review: _______________________

Location of Medication: ☐ on student, emergency medication only ☐ in Health Room ☐ in Classroom

7/2025 cs