School District of Monticello

Prescription Medication Consent

Student _____ Grade _____

Medication _____

Dose to be given _____

Route to be given _____

When to be given_____

Duration to be given (indicate entire school year of specific start/stop dates)

_____

Reason to be given (diagnosis) _____

Possible side effects _____

Medical Provider's signature _____

Date _____Phone number _____

- Medication must be in the original prescription container.

I give my consent to School District of Monticello personnel to administer the above medication to my child according to the above written directions.

I further agree to agree to hold the School District of Monticello, its employees, and agents, who are acting within the scope of their duties, harmless in any and all claims arising from administration of this medication at school to my child.

I give permission to Carolyn Schwartzlow, RN, Monticello School Nurse to contact the above medical provider and/or his/her clinic for any additional needed information or clarification regarding this medication and my child's medical care.

Parent/Guardian Signature _____

Date_____ Phone number_____