

**BUCKEYE LOCAL SCHOOLS
ADMINISTERING MEDICATION
(Other than Medication Prescribed by a Physician)**

**PARENT CONSENT AND INSTRUCTIONS
FOR THE ADMINISTRATION OF
MEDICATION AT SCHOOL**

I am the parent, guardian, or other person having care or charge of

_____, who is a student assigned to
_____ and request that the following medication (which
has not been prescribed by a physician) be administered to him/her. **Medication should be brought to
school directly by the parent in the original container.**

Name of medication

Dosage to be administered

Time or intervals at which
each dosage is to be
administered

Date the administration of
the medication is to begin

Date the administration of
the medication is to cease

Any severe adverse reactions
that should be reported to me

One or more telephone numbers
at which I can be reached in an
emergency

Special instructions for
administration of the medication,
including sterile conditions and
storage

NAME OF PARENT _____
(Please Print)

DATE _____

SIGNATURE OF PARENT _____