RiverStone Health

MEDICATION CONSENT FORM

Name of Child: _____ Date of Birth: _____

School: _____Teacher/Grade: _____

DIAGNOSIS: _____

#1 MEDICATION/DOSAGE:_____

TIME: _____

#2 MEDICATION/DOSAGE:_____

TIME: _____

BEGINNING DATE: _____ ENDING DATE: _____

POSSIBLE SIDE EFFECTS: _____

NAME OF PRESCRIBING HEALTH CARE PROVIDER: _____

I request that the trained designee allow my child to take, or administer my child the medication, as directed above. I authorize the release and exchange of health information from the above health care provider to RiverStone Health and the School. This consent is valid for the current school year. A health care provider's signature will be required for all prescription medication use (longer than two weeks, and as requested by the School Nurse).

Signature of Parent/Guardian Date Phone

_____
Emergency Name and Phone Number

Signature of Prescribing Health Care Provider Date Phone#/Fax#

PARENT NOTE:
Student medication MUST be in the pharmacy bottle or the original bottle for over-the-counter medication. Refer to medication procedure.