WATERTOWN UNIFIED SCHOOL DISTRICT
MEDICATION CONSENT FORM

Child's Name:_____ Date of Birth:_____

School:_____Grade:_____

This Section to be filled out by Parent/Guardian

Non-Prescription Medication

Name of Medication:_____
Dosage:_____
Time to given:_____ (or)
Condition under which medication should be given:_____
Reason for medication: _____
Duration of medication:_____
Possible side effects:_____
Comments:_____

This Section to be filled out by Physician

Prescription Medication

Name of Medication:_____
Route:_____
Dosage:_____
Time to given:_____ (or)
Condition under which medication should be given:_____
Reason for medication: _____
Duration of medication:_____
Possible side effects:_____
Comments:_____

Physician's Signature:_____Phone:_____Date:_____

FOR ALL MEDICATIONS

☐ Inhaler ☐ Diastat ☐ Glucagon Kept In: ☐ Office ☐ Child's Backpack ☐ Other: _____

Parent/Guardian Signature:_____Date:_____

All medication must come in the original container with the student's name on it

FOR ALL MEDICATIONS

Nurse Verified/Signature:_____Date:_____