WATERTOWN UNIFIED SCHOOL DISTRICT
MEDICATION CONSENT FORM

Child's Name:_____ Date of Birth:_____ Weight:_____

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:_____
Student May Self-Carry Inhaler/EpiPen: _____ yes, _____ no
Physician's Signature: _____Phone:_____Date:_____

FOR ALL MEDICATIONS *Students may self-carry EpiPens and Inhalers if Medication Consent is completed by Parent/Guardian and Physician. All other Medications must be kept in designated area in school office. Location of EpiPen: _____ Location of Inhaler: _____
My child may self-carry Inhaler/EpiPen: _____ yes, _____no
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:_____