

**WATERTOWN UNIFIED SCHOOL DISTRICT  
MEDICATION CONSENT FORM**

Child's Name \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

**This section to be filled out  
by Physician**

**PRESCRIPTION MEDICATION**

Name of Medication \_\_\_\_\_

Route \_\_\_\_\_

Dosage \_\_\_\_\_

Time to be given \_\_\_\_\_ (OR)

Condition under which medication should be given \_\_\_\_\_

Reason for medication \_\_\_\_\_

Duration of medication \_\_\_\_\_

Possible side effects \_\_\_\_\_

Comments \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

**This section to be filled out  
by Parent/Guardian**

**NON-PRESCRIPTION MEDICATION**

Name of Medication \_\_\_\_\_

Route \_\_\_\_\_

Dosage \_\_\_\_\_

Time to be given \_\_\_\_\_ (OR)

Condition under which medication should be given \_\_\_\_\_

Reason for medication \_\_\_\_\_

Duration of medication \_\_\_\_\_

Possible side effects \_\_\_\_\_

Comments \_\_\_\_\_

**FOR ALL MEDICATIONS**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

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