

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: _____
Medication Discontinued-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: _____