

Notice to Parents Regarding Medication Policy

Dear Parent/Guardian:

To protect your

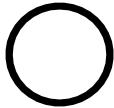
Estimado Padre/ Tutor:

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Para proteger la seguridad de su hijo, la enfermera practicante con licencia de la escuela y/o el asistente de salud (según lo





MEDICATION ADMINISTRATION CONSENT FORM

STUDENT INFORMATION

Student Name:



MEDICATION ADMINISTRATION CONSENT FORM

STUDENT INFORMATION

Student Name: _____ Date of Birth: _____
(Nombre del Estudiante) *(Fecha de Nacimiento)*

Address: _____ City/State/Zip: _____
(Dirección) *(Ciudad/estado/código postal)*

School: _____ Grade: _____ Teacher: _____ School Year: _____
(Escuela) *(Grado)* *(Maestro/a)* *(Año escolar)*

List any known drug allergies/reactions: _____ Height (inches): _____ Weight (lbs.): _____
(Alergia/Reacción Conocida a Medicamentos) *(Altura)* *(Peso)*

Parent Name: _____ Phone Number: _____
(Nombre del Padre) *(Número de Teléfono)*

PHYSICIAN AUTHORIZATION

(To be completed by physician/licensed prescriber)

Name of Medication: _____ Reason for taking: _____

Dosage: _____ Route: _____ Time(s) and Interval to be administered: _____

Is the student able to self- ~~stud~~(s)-~~st~~(s)-~~st~~(s)-~~st~~(s)