Please return to

HERITAGE CHRISTIAN ACADEMY

Email: nurse@heritagechristianacademymn.org **Fax:** 763-463-2293

Medication Administration Consent Form

Name of Student: _____ **Birthdate:** _____

School: Heritage Christian Academy **School Year:** _____ **Grade:** _____

Medical Condition	Medication	Dosage/Amount	Time	Route	Possible Side Effects
1.					
2.					
3.					

Other Considerations/Directions: _____

Start Date: _____ **Stop Date:** _____

(Print) Name of Physician/Licensed Prescriber

Signature of Physician/Licensed Prescriber

Clinic Address

Phone Number Date

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) to be given on field trips, as prescribed.
2. I release school personnel from liability in the event of adverse reactions resulting from taking the medication(s).
3. I will notify the school of any change in the medication(s). (example: dosage change, medication is discontinued, etc.)
4. I give permission for the nurse to communicate with the student's teachers about the student's health condition and the action of the medication(s).
5. I give permission for the nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition being treated by the medication(s).
6. I give permission for the medication(s) to be given by designated personnel as delegated by the nurse.

☐ **If there is remaining medication, I give permission for the school to send this home with my child.**

Date Parent/Guardian Signature Telephone # Relationship to Student

Note: Medication is to be supplied in the original/prescription bottle.