CAMPBELL COUNTY SCHOOLS
CONSENT FORM FOR ADMINISTERING MEDICATION AT SCHOOL

Student's Name _____ **Grade** _____

Name of Medication _____

Dosage _____

Route of Administration _____

Time(s) To Be Given _____

Diagnosis Or Reason For The Medication To Be Given _____

Possible Side Effects: _____

Student's Allergies: _____

Name of Prescribing Doctor _____

_____ _____

Signature of Prescribing Doctor **Date**

Phone Number of Prescribing Doctor _____

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I request my child be permitted to take medication as outlined above and expressly waiver any liability on behalf of the school as a result of administration of the above drug(s) and do hereby give permission for a mutual exchange of medical information between the physician that authorized this medication and a designated representative of Campbell County Schools.

_____ _____

Signature of Parent/Guardian **Date**

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Name of School Submitted To

Revised 7/09