Agua Fria Union High School District
Consent to Administer Prescription Medication at School

Check School: ✓							
	_____		_____		_____		_____

Student Name: _____ Date: _____
(PRINT) Last First Middle

Grade: 9 10 11 12 Date of Birth: _____

As parent/guardian of the above-named child, I hereby request and give my consent for the school nurse or person designated by the school administration to see that the above-named student receives the following medication for the period from _____/_____/_____ to _____/_____/_____.

The medication is to be provided to the school nurse in the original labeled container and must contain:
Name of Medication: _____

Dose to be Administered: _____

Time of Day to be Administered: _____

Duration of Treatment: _____

Prescriber's Name (Must be on the Label): _____

Reason for Medication: _____

Parent/Guardian gives permission for student to carry and Epi-Pen and/or inhaler.
Parent/Guardian Signature: _____ Date: _____

Comments: _____
_____
_____

Parent/Guardian (Print Name): _____
Parent/Guardian Signature: _____ Date: _____
Phone Number Where Parent/Guardian Can Be Reached: _____