



**PLEASANT GROVE ISD
MEDICATION CONSENT FORM**

**PERMISSION IS REQUIRED TO ADMINISTER ALL PRESCRIPTION AND NON-PRESCRIPTION
MEDICATIONS AT SCHOOL.**

FOR "AS NEEDED" MEDICATIONS GIVEN LESS THAN 15 CONSECUTIVE DAYS

Student Name: _____ Grade: _____

Name of Medication(s): _____

Time to be Given: _____ Amount to be Given: _____

Reason for Medication: _____

Send only small bottles of medication to school in properly labeled original containers with the student's name on the medication bottle. Students cannot carry or transport medication at school.

By signing, I authorize school personnel to administer medication to my child as needed for reasons stated above. I also understand that it is my responsibility to pick up medication at the end of the school year. Failure to do so will result in medications being disposed of, as they cannot be left in the health office over the summer.

Parent/Guardian Signature: _____ Date: _____

Phone Number: _____

**FOR ROUTINE MEDICATIONS GIVEN MORE THAN 15 DAYS
PHYSICIAN SIGNATURE REQUIRED**

Student Name: _____ Grade: _____

Name of Medication(s): _____

Time to be Given: _____ Amount to be Given: _____

Reason for Medication: _____

Physician Signature: _____

Send the prescription bottle with the pharmacy label. We must have a current bottle. Students cannot carry or transport medication at school.

By signing, I authorize school personnel to administer medication to my child daily for reasons stated above. I also understand that it is my responsibility to pick up medication at the end of the school year. Failure to do so will result in medications being disposed of, as they cannot be left in the health office over the summer.

Parent/Guardian Signature: _____ Date: _____

Phone Number: _____