Medford Area Public Schools

PARENT-GUARDIAN MEDICAL CONSENT FORM

Full Name of Child: _____

Name of Drug and Dosage: _____

Hour medication is to be given: _____

Name of Physician: _____

Is this medication prescribed by your physician? ☐ Yes ☐ No

Reason for Medication: _____

I hereby give my permission to give the medication indicated to my child according to the direction stated above and to contact the child's physician if necessary.

I further agree to hold the Medford School District harmless in any and all claims arising from the administration of this medication in school.

I agree to notify the school in writing at the termination of this request or when any change in the above orders is necessary.

_____ _____

Signature of Parent/Guardian Date

If a medication is ordered by the physician, both this form and the physician medication form on the reverse side must be returned to the school.