School Year:_____

Elder Grove School
Prescription Medication/Treatments Consent form

HEALTHCARE PROVIDER SECTION (Order only medications/treatments that are **required during** school hours)

Name of Student: _____ Date of Birth: _____Grade: _____

Medication Allergies: _____

Medication: _____

- **If medication is for asthma rescue or anaphylaxis, please use Asthma/Quick Relief Bronchodilator Medication Authorization or Anaphylaxis Action Plan form.**

Purpose of Medication:

_____

Administration Time of Medication _____. If medication/treatment is not taken at above time (+/- 60 minutes) how late can it be given? _____

Possible Side Effects: _____
***Duration of Order: Valid until end of school year unless otherwise noted.*_____**
Other length of duration: _____

_____ _____ _____ _____
Provider Printed Name Provider Signature Phone # Date

Form must be completed prior to medication being administered.
Elementary School Fax 406-651-4346 Middle School Fax 406-656-7893

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Parent/Guardian Section

- I give permission for the above named student to take the above medication at school as ordered.
- I understand the medication will be given by a school nurse or school staff member.
- I will bring the medication to the school myself or by another responsible adult.
    - Students are not allowed to carry medication unless allowed to do so by law or specific school plan.
    - Students will not be given narcotic medications unless allowed by a specific school plan.
- I will bring the medication to school in the original container, appropriately labeled by the pharmacy stating name of medication, dosage, student name.
- I agree that the health care provider and school nurse may communicate based on this medical authorization as needed. Communication may only include medication/treatment itself, implementation of the treatment in school and student outcomes of the treatment. .
- I understand that I will also need to complete a medication drop off and pick up form regarding the above medication for drop off and pick up procedures.

_____ _____ _____ _____
Parent/Guardian Printed Name Parent/Guardian Signature Phone # Date

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School Nurse Signature: _____ Date Order Reviewed:_____