Consent Form
Temporary Medication for Children at School

CHILD’S NAME__________________________________________

GRADE__________________________________________

MEDICAL CONDITION__________________________________________

Does this condition require any medication at school  YES/NO

If YES, MEDICATION REQUIRED ________________________

______________________________

QUANTITY__________________________________________

______________________________

TIMES/CONDITIONS TO BE TAKEN ________________________

START DATE________ FINISH____________________

______________________________

SIGNATURE OF PARENT/GUARDIAN____________________

DATE:______________________________

*Please ensure your child’s name is clearly marked on their medication