2023-2024 School Year

Turtle Lake School District Medication Consent Form

Student Name: _____ Allergies: _____

School: _____ School Year:_____ DOB:_____ Grade:_____

Over the Counter Medications							
Medication	Dosage	Route	Frequency	Time(s)	Start Date	Stop Date	Reason for Admin.

Parent/Legal Guardian Consent (needed for all medication administration at school):

Medication will be provided by the parent/guardian in its original container or prescription-labeled container.

I hereby give permission for school personnel to administer the medication(s) listed on this sheet to my child according to the practitioner and/or my instructions. I authorize them to contact the practitioner for a question or concern. I further authorize the practitioner to render treatment to my child, as appropriate and necessary, from administering the medication.

Parent/Guardian Name: _____ Phone Number:_____

Signature: _____ Date:_____

Prescription Medications (to be completed by the provider)							
Medication	Dosage	Route	Frequency	Time(s)	Start Date	Stop Date	Reason for Admin.

Practitioner Information (needed for all prescription medication administration at school):

Practitioner Name: _____

Practitioner Signature:_____ Date: _____

Clinic: _____ Phone: _____