

Cowan Community Schools  
Medicine Consent

Student \_\_\_\_\_

Date of Birth \_\_\_\_\_

**Prescription Medication:** A copy of the original physician prescription, a faxed order from the physician or a copy of the pharmacy label is required and to be kept on file. Medicine must be in the labeled original pharmacy container.

**Parent Agreement:** It is highly recommended that parents transport any medicine to and from school. If you choose to send medicine to school with your student, the statements below must be initialed:

\_\_\_\_\_ *I accept the liability that my student is responsible and will not share or sell medicine with other children, will not take medication on his or her own while transporting to school or home and will bring the medicine to the school office at the beginning of his or her day.*

**Over the Counter Medication:** Non-prescription medication must come to school in the original container from the store.

Name of Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

\*\*\*of Pills sent \_\_\_\_\_ (Controlled Substances Only)

\*\*\*Controlled substances such as Ritalin (Methylphenidate), Adderall (Amphetamine), Vyvanse, or any Narcotic pain medicine must have a pill count on this form and on any refills sent in during this school year.

Reason to give medication: \_\_\_\_\_ (examples: pain, itching, hives, coughing, headache)

Time of day required: \_\_\_\_\_ AM or PM \_\_\_\_\_ check here for use on as needed basis.

Method of administration: (circle one) by mouth \_\_\_\_\_ injection \_\_\_\_\_ apply to skin \_\_\_\_\_

Ear drops: Right \_\_\_\_\_ Left \_\_\_\_\_ Eye drops: Right \_\_\_\_\_ Left \_\_\_\_\_ Other \_\_\_\_\_

Special instruction including storage or sterility requirements: \_\_\_\_\_

Date medication will be started in school: \_\_\_\_\_

Date medication will no longer be needed in school: \_\_\_\_\_ (Specific Date) OR \_\_\_\_\_ (End of School Year)

\*If medication needs to be stopped before this date or extended after this date, a written note, fax, phone call, or email must be sent by parents.

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Please Note:

- The school must follow over the counter label directions. (For example, if directions are not to give to children under 12 years of age we must have a physician's written statement to administer if the child is under 12 years old.)
- Parents must notify the school and fill out a new medicine consent form if there is a change of dosage. An updated medicine bottle with the new dose on the label must be provided as well.
- **All medications need to be picked up and brought in by a parent/guardian**

I give permission for Cowan School Corporation to administer medication to my child as directed above.

Parent Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_