FORM C

GLOUCESTER COUNTY PUBLIC SCHOOLS
MEDICATION CONSENT FORM

We attempt to discourage administration of medication during school hours and request that whenever possible medication be administered at home. We realize that this is not always possible and will cooperate in the administration of medication when needed.

1. **PRESCRIPTION MEDICATIONS:** The physician must complete this form detailing the name of the drug, dosage, and time intervals that the medication is to be taken. The parent or guardian must sign this form requesting that the school district comply with the physician’s order. Medication must be brought to school in a container appropriately labeled by the pharmacy or physician. Asthma Action Plans, Diabetes Management Plans, Emergency Action Plans, etc. do not require the medication consent form as long as they are completely filled out and signed by the doctor, parent, and school nurse.

2. **OVER THE COUNTER MEDICATIONS:** All over the counter medication must be in the original container and be provided by the parent or guardian. The parent or guardian must complete this form requesting that the school district administer the medication.

3. If medication is brought to school by the student, the appropriately labeled container must be placed in a sealed envelope. The number of pills being sent must be indicated on the envelope.

4. All medication must be kept in the school clinic. Violations of this policy could place the student in violation of the Substance Abuse Policy.

5. Medication MUST be picked up by the parent/guardian or designated adult. ALL medication not picked up by the last day of school will be destroyed.

**PLEASE FILL IN AND SIGN THIS FORM (one medication per form):**

Student’s LEGAL Name: ____________________________________________

Date of Birth: ___________________ Grade: ___________ ID#: ______________________

Date of Order: ___________________ Allergies: ______________________________________

Condition Being Treated: __________________________________________

Name of Medication: _________________________________________________

Dose and frequency: ________________________________________________

**Possible side effects:** _____________________________________________

Duration of Order: __________________________________________________

_________________________________________________________  Signature of Physician  Telephone Number

Physician’s Stamp  Signature of School Nurse  Expiration Date of Medication: ________________________

I request that the school give the above medication.

_________________________________________________________  Signature of Parent/Guardian  Date  Daytime Telephone

_________________________________________________________  Fax#: __________________________

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