Call us toll-free at 866-SEIZNET (734-9638)
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Medicine Consent Form

Name of student: ____

Name of school: ____

Address: ____

Phone: (H) _____________________________ Phone: (W) _______________________________

Name of medicine: ____

Reason for medicine: ____

Dosage: _________________ Route: ______________ Time: _________________

Any special way to give medicine: ____

Possible side effects: ____

Any particular side effect to watch for: ____

What to do if child misses a dose: ____

Prescribing physician: _______________________________ Phone: ____________________________

Clinic nurse: _______________________________________ Phone: ____________________________

I agree to notify the school in writing at the termination of this request or when any change in the above medication is necessary. I authorize the school as above to administer the medication as ordered at the designated time.

Parent's signature: ________________________________ Date: _________________

The above orders shall be effective through _______________ unless discontinued or changed by the provider.

Provider's signature: ______________________________ Date: _________________