PARENTAL / GUARDIAN CONSENT FOR HANKINSON PUBLIC SCHOOLS TO PROVIDE MEDICATION

Student's Last Name: _____

Student's First Name: _____

Grade: _____ Gender: _____

Date of Birth: _____ / _____ / _____

MEDICATION AUTHORIZATION

NOTE: Fields marked with an (*) must be completed by a healthcare provider for **prescription medication**.

*Medication's Name: _____

*Diagnosis / Reason for Medication : _____

*Dosage (amount): _____

*Time(s) of the Day: _____

Dates Medication must be provided at School:
_____Short Term: (List the dates to be given.)_____
_____Everyday as directed by healthcare provider

I am the parent or guardian of _____.
I give my permission for him/her to take the above mentioned medication at school. I acknowledge that all medication must be brought to and stored in the school's office.

Parent / Guardian Signature: _____

Date: _____