Location:

Plymouth Meeting Friends School

MEDICATION CONSENT FORM

School Year 20 __/___

I give my consent for Plymouth Meeting Friends School staff to supervise my child taking the following medication(s).

Student Name _____ Grade _____

Name of Medication _____ ☐ Prescription

☐ Non-Prescription

Dosage _____ Frequency _____

Reason for Medication _____

Effective dates: from _____ to _____

Other pertinent information _____

_____

Both parent and physician signatures are required.

_____ _____

Parent Signature Date

_____

PRINT Parent Name

_____ _____

Physician Signature Date

_____

PRINT Physician Name

Return to PMFS Main Office, attached to medication.

Office Use Only:

___*Update in database*
___ *Emergency meds: Update confidential list*
___ *Update to Teacher, Admin, X-day (as nec.)*
___ *Daily meds: create medication record*
___ *Original to School Nurse for file*
___ *Copy to teacher (keep with student info forms)*
___ *Copy with medication*
___ *Copy in Binder*

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