Consent Form
Temporary Medication for Children at School

CHILD'S NAME___________________________________

GRADE____

MEDICAL CONDITION______________________________

Does this condition require any medication at school YES/NO

If YES, MEDICATION REQUIRED_____________________

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QUANTITY____

TIMES/CONDITIONS TO BE TAKEN___________________

START DATE________________ FINISH_________________

____

SIGNATURE OF PARENT/GUARDIAN__________________

DATE:____

*Please ensure your child's name is clearly marked on their medication