KEYSTONE
Center for Children with Autism
Educating Children · Supporting Families · Inspiring Possibilities

Medication Consent Form

Medications are to be administered at home whenever possible. If it is necessary for a student to receive medication at school, all appropriate portions of the form MUST be completed before medication can be given at school. One form for EACH medication is required.

Student Name					
Type of Medication		Start Date		End Date	
Dosage		Frequency			
Possible Side Effects					
If PRN (as needed), describe conditions under which to administer					

Permission is given to the school to administer an early A.M. dose of medications, if forgotten at home (per parent/guardian request).

Parent Guardian Consent:

(Complete for all prescription and non-prescription medication/procedures at school.)

- I request and authorize that this medication be administered at school, by school personnel.
- I will supply medication in its original, updated, properly labeled containers.
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
- I understand that when medication at school is no longer needed, an adult must pick up remaining medication. *It will not be sent home with the child.*
- I understand that all medication should be delivered to the school by a parent/guardian.
- I understand that medication will be given by non-medically trained school personnel.
- I agree to hold Keystone Center for Children with Autism, Inc., it's employees and agents who are acting within the scope of their duties, harmless in any and all claims arising from the administration of this medication at school.

The above medication is to be administered during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication.

____
Printed Name of Parent/Guardian

____ ____________
Signature of Parent/Guardian *Date*

Physician Name ____

Address ____

City ________________ State ________ Zip Code _________ Phone ______________

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