# Lomega Public Schools

## Parent Consent Form for Student Medication Administration

Date: ________________________________

I have read the medication label, and my child does not have any health problems that could be worsen by taking this medication. My child is not taking any other medication(s) at home that could interact with this medicine and cause unwanted side effects. I will notify the school in writing if I want this medication discontinued. Otherwise, I understand that it will be kept in the school office and will be administered as listed below for the current school year by designated school employee.

Fill out completely and return to school with the medication that will be administered.

STUDENT NAME: ____________________________________DOB: _____________________

TEACHER/GRADE: _____________________________________________________________

MEDICATION: _________________________________________________________________

PURPOSE OF MEDICATION: ____________________________________________________

PRESCRIPTION: ____ NON-PRESCRIPTION: ____ DATES GIVEN: _________________

METHOD: ___ Liquid ___Tablet ___ Inhaler ___ Topical Drops: ___Eye R L ___ Ear R L

DOSAGE: ____________________________ TIMES TO BE GIVEN: _________________

_____________________________________

SPECIAL INSTRUCTIONS/ALLERGIES: ___________________________________________

_______________________________________________________________________________

**I, ___________________________________ (Parent/Guardian Name) give Permission to Authorized Staff member(s) to administer medication to my child as indicated above.**

_______________________________________________ ___________________________

**Parent/Guardian Signature** **Date**

**Elementary – 409 Main St, Loyal, OK 73756 ● Phone 405-729-4251 ●Fax 405-729-4252**
**High School – 18319 N 2700 Rd, Omega, OK 73764 ● Phone 405-729-4281 ●Fax 405-729-4666**