MEDICATION CONSENT FORM
COVENTRY PUBLIC SCHOOLS
COVENTRY, R.I.

Student: _____ Date of Birth: _____

Grade: _____ Room: _____ Date form received by the school: _____

To be completed by the physician or authorized prescriber

Diagnosis/Reason for medication: _____

Name of medication: _____

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐Injection ☐ Nebulizer ☐ Other _____

Instructions:

Dosage: _____ Time to be given: _____

If medicine is to be given p r n, describe indications: _____

Start: ☐ Date form received ☐ Other date: _____

Stop: ☐ End of school year ☐ Other date: _____

Restrictions and/or important side-effects:

☐ None anticipated ☐ Yes. Please describe: _____

Special requirements/Field trips

This student is both capable and responsible for self-administering this medication:
☐ Yes ☐ Yes, with adult supervision ☐ No

This student may carry this medication: NOTE- this does not apply to controlled substances ☐ Yes ☐ No

This medication may be omitted on a field trip: ☐ Yes ☐ No

Date: _____ Physician's Signature: _____

Physician's Name: _____

Address: _____

Phone Number: _____

To be completed by parent/guardian

I give permission for _____ to receive the above medication at school according to standard school policy.

Date: _____ Signature: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please refer to the District medication policy summary located in the school handbook or request a full copy of Policy # 8144 (Student Welfare/First Aid and Medication) available upon request from your School Nurse Teacher.