WESTLAKE CITY SCHOOLS - PARENT CONSENT AND PHYSICIAN ORDER

FOR ADMINISTRATION OF MEDICATION AT SCHOOL

PARENT CONSENT

I hereby request and give permission to the Project Link Staff to supervise administration to

my child____

The medication and/or medical procedure____

As prescribed by Dr.____in the order below.

PHYSICIAN'S ORDER
(All blanks must be completed)

STUDENT'S NAME:_____________________________________ Date:____________________

I. MEDICATION:____

Route:____________________________ Dosage:_______________________________

Time of administration:____

Start Date:___________________________ Stop Date:___________________________

Adverse side effects which should be reported to physician:_____________________________

____

Special instructions for administering medication and/or storage requirements:_______________

____

II. MEDICAL PROCEDURE____

Time of procedure:____

Start Date:___________________________ Stop Date:___________________________

Special instructions for cleaning and storage of equipment and sterile requirements:___________

____

III. PHYSICIAN'S NAME:____

Physician's signature (required):____

Date:_________________________ Business Phone: (   )__________- ___________

Business address:____