International
CHARTER SCHOOL

Teaching in the languages of our community: English, español, Português

Medical Authorization & Consent Form

A certified School Nurse-Teacher has permission to administer the medication prescribed below to my child.

Student Name:________________________ Date of Birth:__________ Class: ________ Grade:________

The school physician and or nurse teacher has permission to discuss medical issues with the prescriptive issuing physician/dentist.

❑ Yes ❑ No I give permission to the School Nurse-Teacher to share with appropriate school personnel information relative to the prescribed medicine administration, e.g. adverse side effects, as s/he determines necessary for my daughter/son's health and safety.

Parent/Caregiver Signature	Date	Home Phone	Work Phone	Cell Phone

Physician/Dentist Medication Information
(The following is to be completed by the physician/dentist)

Diagnosis for which medication is given:____________________

Name of Medication:____________________

Form of medication (e.g. liquids, tabs, etc.):____________________

Dosage:____________________

Time to be given:____________________

If medication is to be given "when needed", describe indications:____________________

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Length of time medication is to be given:____________ Expiration date:____________

Significant side effects:____________________

May the student self-administer and carry his/her inhaler? ❑ Yes ❑ No

If the child is on a field trip, may medication be omitted? ❑ Yes ❑ No

Hospital child should be transferred in case of emergency? ____________________

Other Information: ____________________

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Physician's/Dentist's Signature	License No.	Date	Phone No.

Medical Permission Document – Rev. 9/30/04

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