THE SEED SCHOOL OF MIAMI
STUDENT MEDICATION ADMINISTRATION INFORMATION & CONSENT FORM

STUDENT NAME: _____ **Date of Birth**: _____ **Grade:** _____

Please provide an updated list of medications your student is taking daily or may need to take occasionally. Additional space can be found on page 4. ***Please sign the consent at the end of page 3.***

MEDICATION INFORMATION (REQUIRED – if applicable)

Date first prescribed (began to take it)	Prescribing Physician (Doctor's Name, Address & Phone Number)	Pharmacy Name and Phone Number	Name of Medicine	How much is taken? (Dosage)	When is it given? (Schedule)	What is it used for? (Purpose and Diagnosis)	How often do you get need to get a refill? OR New Prescription?

THE SEED SCHOOL OF MIAMI
STUDENT MEDICATION ADMINISTRATION INFORMATION & CONSENT FORM

STUDENT NAME: _____ **Date of Birth**: _____ **Grade:** _____

Please provide a list of OVER THE COUNTER medications your student is taking daily or may need to take occasionally and sign the consent at the end of the form. Below are some *examples* of over the counter (OTC) medication (does not list all available.) These will be available to all students in case of minor illnesses. However, if your child takes these types of meds or any other over the counter meds ***at least once per month***, you ***must*** provide them to the school for their personal use.

MEDICATION INFORMATION (REQUIRED) **WRITE YES OR NO UNDER EACH COLUMN TO IDENTIFY YOUR PREFERENCE**

OVER THE COUNTER MEDICATION TYPE Check √ next to name for Yes Mark X next to name for No	AUTHORIZED TO ADMINISTER	PLEASE CALL ME BEFORE ADMINISTERING	PLEASE CALL ME AFTER ADMINISTERING	I AUTHORIZE YOU TO ADMINISTER WITHOUT CALLING ME	MY CHILD MAY NEED TO TAKE THIS MEDICATION MORE THAN ONCE PER MONTH
Ibuprofen: Advil __ Motrin __					
Antihistamines: Benadryl ___ Zyrtec ___ Claritin ___					
Acetaminophen: Tylenol ___					
Cold Medicine or Decongestants: Robitussin ___ Cough drops ____					
Stomach Upset: Pepto Bismol ____					
OTHER(S): PLEASE LIST BELOW Neosporin ____ Icy Hot ____					

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Additional Information or Comments

_____

_____

_____

_____

_____

Medication Administration Consent

By signing below, I grant permission to The SEED School of Miami designated employee trained on medication administration or a Jessie Trice nurse providing services at The SEED School of Miami to administer the above medication (prescribed or over the counter) to my child _____.

Student Name

_____ _____

Parent/Guardian Signature Date

STUDENT NAME: _____ **Date of Birth**: _____ **Grade**: _____

MEDICATION INFORMATION (REQUIRED – if applicable)							
Date first prescribed (began to take it)	**Prescribing Physician (Doctor's Name, Address & Phone Number)**	**Pharmacy Name and Phone Number**	**Name of Medicine**	**How much is taken? (Dosage)**	**When is it given? (Schedule)**	**What is it used for? (Purpose and Diagnosis)**	**How often do you get need to get a refill? OR New Prescription?**