Medication Consent

(Medication must be provided in its original container that lists the child's name and dosing information.)

PARENT/GUARDIAN, please complete the following:

______________________________ ______________________________
Name of Student (Please print) Program

I hereby request that an authorized representative of AYS administer the medication listed below to my son/daughter. I understand that I may withdraw this consent at any time by submitting a written request to AYS personnel. Furthermore, I understand this consent is valid for only one school year.

______________________________ ____________________
Parent/Guardian Signature Date

PHYSICIAN, please complete the following:

______________________________ is a patient under my care. The following medication would need to be administered during the AYS program. The following is a description of the medical order:

Name of the prescription medication: ______________________________

Dosage and directions for administration: ______________________________

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Purpose: ______________________________

Possible side effects to be reported and monitored for: ______________________________

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______________________________ ____________________
Physician Signature Date

____
Physician Printed Name

Rev. 5/02; 7/09; 3/17

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