



Memorial Christian School & Daycare

4905 South Highway 16 | Rapid City, SD 57701

PARENT MEDICAL CONSENT FORM

_____ to my child _____
(Name of Rx and dosage) (Child's Name)

Grade/Teacher _____ At the time indicated below (check which)

Give medication at the specified times:

○ ____:____ am / pm o'clock

○ ____:____ am / pm o'clock

○ ____:____ am / pm o'clock

As necessary to control asthma/wheezing for which this medication was specifically prescribed, but no more often than every ____ hours.

As is necessary _____

The medication shall be provided in a bottle showing the name of the pharmacy, student's name, physician's name and the dosage of the medication to be given.

I absolve the school personnel of all responsibility for any unforeseen development or reaction attributable to the administration of the above name medication. It is the responsibility of the child to come to the office to take his/her medication.

This authorization will terminate completely on _____
(Specific Date)

(Parent/Guardian Signature) (Date of Authorization)

Physician signature/instructions for dose(s) other than noontime _____.

