UNIVERSAL MUSLIM ACADEMY

2232 Stratford Av
Cincinnati, Ohio 45219
513-421-0700

Parent/Guardian Medication Consent Form

Please complete this form and return along with medication(s) to the school office.

Full name of child to be medicated _____

Name of drug and dosage _____

Hour(s) medication to be given _____

Number of days to be taken _____

Name of physician prescribing medication _____

Physician's phone number _____

Reason for medication _____

I hereby give permission to the Health Room/Office Personnel to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold the School, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.

I agree to notify the school, in writing, at the termination of this request or when any change in the above order is necessary.

_____ _____

Signature of Parent/Legal Guardian Date

_____

Address

_(_____)_____ _(_____)_____

Home Phone Work Phone

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To Be Filled Out By Physician

To _____
Individual(s) Administrating Medication

Please administer the following medication(s) to:

Name of Student _____ Address _____

Telephone Number_____ UMA Grade _____ Diagnosis _____

Physician Medication Orders: DAILY MEDICATIONS

Medicine	Route	Dose	Frequency	Duration	Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state)
				From: To:	
				From: To:	
				From: To:	

PRN MEDICATIONS (AS IS NEEDED)

Medicine	Route	Dose	Frequency	Duration	Condition under which medication should be given	Direct contact shall be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state)
				From: To:		
				From: To:		
				From: To:		

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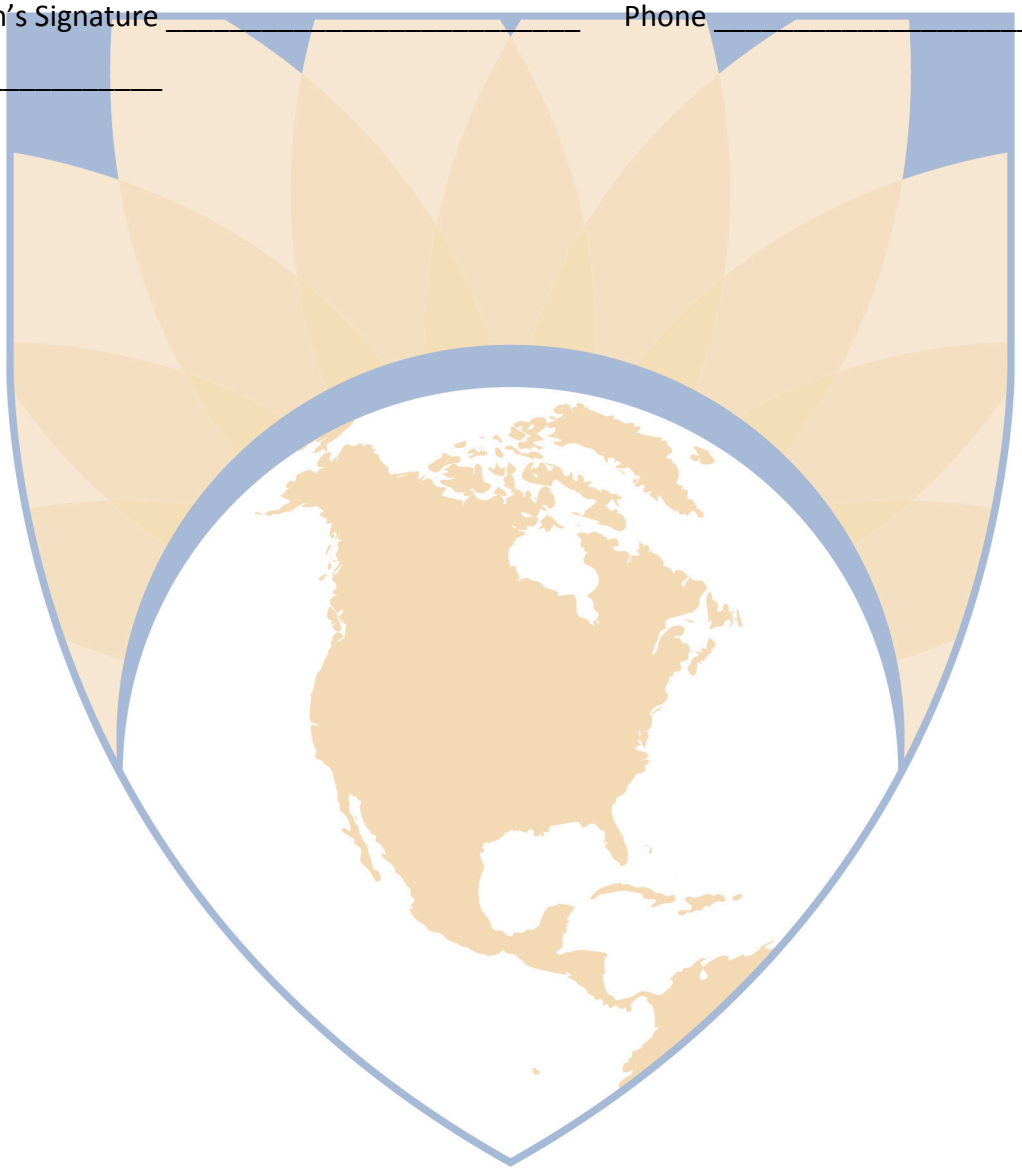
The information on this form constitutes my physician medication orders for the subject student. I agree to retain the power to direct, supervise, decide, inspect and oversee the administration of such medication(s). Direct contact shall be made with me at any time should you have any questions.

Hospital/Clinic/Office _____ Address _____

Physician's Signature _____ Phone _____

Date _____