

MEDICATION ADMINISTRATION CONCENT FORM

Student's name (please print) _____ Grade _____

Medications, including those for self-medication, must be in the original contained and be properly labeled with the student's name, the ordering provider's name, the name of the medication, the dosage, frequency, and instruction for the administration of the medication (including times). Additional information accompanying the medication shall state the purpose for the medicating, its possible side effects, and any other pertinent instructions (such as storage instructions) or warnings.

I hereby authorize the school nurse or his/her designee to administer the following medication(s) to my child.

Name(s) of medication _____

Name of physician or dentist (if applicable) _____

Dosage _____

Instructions for administering the medication _____

Other Instructions _____

In case of emergency, name of person and phone _____

Doctor to be called _____ Phone _____

Hospital _____ Phone _____

I acknowledge that the District, its Board of Directors, and its employees shall be immune from civil liability for damages resulting from the administration of medications in accordance with this consent form.

Parent or legal guardian signature _____

Date _____

MEDICATION ADMINISTRATION RELEASE FORM

STUDENT _____	DATE _____	
ID# _____	DOB _____	ALLERGIES _____
SCHOOL _____	GRADE _____	TEACHER _____

TO BE COMPLETED BY PRIMARY CARE PROVIDER

MEDICATION _____	
DOSAGE _____	TIME TO BE ADMINISTERED _____
REASON FOR MEDICATION _____	
POSSIBLE SIDE EFFECTS _____	
SPECIAL INSTRUCTIONS _____	
PHYSICIAN/NP/PA SIGNATURE _____	
OFFICE TELEPHONE _____	DATE _____

TO BE COMPLETED BY PARENT

IN CASE OF EMERGENCY _____	HOSPITAL _____
PARENT _____	PHONE _____
ALTERNATE _____	PHONE _____
HEALTH CARE PROVIDER _____	PHONE _____

I request that you give medication to my child during the school day in accordance with the School District Medication Policy. I understand that in the absence of the school nurse, a designated staff member, instructed in the safe procedure for medication administration may give this medication.

Parent/Guardian Signature

FOR OFFICE USE ONLY

INSTRUCTIONS GIVEN TO PERSONNEL <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE _____
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