Parental Consent for Medication Administration at School

Student Name:		**School:**
Date of Birth:	**Grade:**	**Medication Start Date:**

Parent/Guardian must complete the following information for each medication to be given at school (one form per medication). Medication must be delivered to the school in the original container with the label intact. The medication is to be given in the following manner:

Medication Name:	
Medication Strength:	**Amount to be Given:**
Time to be Given:	**Give on Early Release Days? NO YES**
Route to be Given (by mouth, inhaled, etc.):	
Medication Expiration Date:	**Date to Discontinue Medication:**
Prescribing Physician:	**Office Phone:**
Reason for Medication:	**List Known Allergies:**

I authorize the School District, health staff, or other person designated by the administrator, on my behalf, to assist in the administration of the medication identified as ordered by my child's physician.

I understand the law provides that there shall be no liability for civil damages as a result of the assistance in administration of such medication and/or treatment where the person assisting in the administration of such medication and/or treatment acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I understand my child's medication is to be presented to a school representative by an adult. I will assume full responsibility for the supply, appropriatiate transportation, and maintenance of the above medication. If any changes in medication or dosage occur, the school must be notified immediately, and a new form must be completed. I give my permission for the exchange of information directly with the healthcare provider regarding my child's medications. I understand that an adult must pick-up my child's medications on their last day of attendance. Remaining medication will be properly disposed of after the child's last day of school.

______________________________ Parent/Guardian Signature

______________ Date

______________________________ Parent/Guardian Personal Phone Number

______________________________ Parent/Guardian Alternative Phone Number

Do Not Write Below this Line: Health Office Use Only

Health Plan:

The student will receive 15 minutes of nursing services for administration of the above medication at school __________ (frequency) for treatment of ______________________ beginning on ______ until __________(date).

______________________________ Printed Nurse Name

______________________________ Nurse Signature

Date

Parent Discontinued/Picked up Medication	Date	Parent Initials
Wasted Medication	Count	Staff Initials

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Medication Refill Log

Date of Refill	Pill Count	Dose Count	Parent/Staff Initials
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Date of Refill	Pill Count	Dose Count	Parent/Staff Initials
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Receiving Staff Member

Signature: Initials:

Signature: Initials:

Signature: Initials:

Field Trip Medication Documentation

Date Given	Time Given	Given By (Print)	Signature