PARENT’S/GUARDIAN’S CONSENT FOR GIVING MEDICATION AT SCHOOL

I hereby request and give consent for the school nurse or person designated by the administrator to give the following medication as directed. I understand the Health Office does not supply any medication to students. All medication is to be brought to and from the Health Office by parents/guardians.

The Health Office does not administer expired medication. All medication must be age appropriate.

Student name: _____________________________________ Grade: __________ Name of medication: ___________ ______________________

☐ Prescription ☐ Over-the-counter ☐ Daily ☐ PRN (as needed) Prescription #: __________________ Expiration date: ______________

Amount/dosage to be given: ____________ Time to be taken: ___________ Route: ___________ Reason for medication: ____________________

Duration of treatment: _________________ Prescriber’s name (must be on label): ___________________________________________________________________________________________

Student allergies: ____________________________ Other medication(s) being taken: ______________________________________________________

I furnish this medication and if it is a prescription, it must be in the original pharmacy bottle, labeled with my child’s name, prescription number, and name of medication, dosage, route, and the number of times a day medication is to be administered. The Health Office has a small volume nebulizer but the parent/guardian must provide individual tubing and mask or T-piece.

If it is an over the counter medication, it must be in the original container, the date, the time to be given, route, the amount to be given must be entered above. All medication must be brought to the Health Office where it will be kept in a locked cabinet. The student must take his/her medication in the Health Office. The school district personnel will not be responsible or liable for any reaction to the medication(s) given.

THE SCHOOL MUST BE NOTIFIED IMMEDIATELY IN WRITING OF ANY CHANGE IN MEDICATION.

Signature Parent/Guardian: __________________________ Date: ________________

Home phone number: (_____ ) ___________ Cell phone number: (_____ ) ___________ Work number: (_____ ) ___________

If required this portion must be completed by the Health Office staff

☐ Current school year Action Plan completed signed and dated by healthcare provider ☐ Date received: ______________

☐ Healthcare provider note to carry and self-administer medication at school and school events ☐ Date received ___________

☐ If student to self-carry medication instruct parent/guardian/student he/she must carry it and prescription in front pocket of his/her backpack

☐ Any of above have X, contact student’s teachers/administration via email, let be aware and document in computer ☐ Date email sent: ______

Health Office staff must complete this portion when medication is picked up or discarded

Date medication picked up: ________________ Signature Parent/Guardian: ___________________________________________________________________________________________

RN or HA signature: ___________________________________________________________________________________________

Discard/expired ☐ Expiration date: ________________ ☐ Discarded/left after pickup date: ________________

☐ Self-addressed envelope completed by Parent/Guardian ☐ End of year letter sent to parent/guardian ☐ Date sent: ________________