

CONSENT FOR MEDICATION ADMINISTRATION

This form MUST be signed and turned in to the office for medications to be given at school.

1. For student safety, **all medication should be brought to school by the parent. Controlled substances MUST be brought to the school by the parent and administered by authorized staff.** No medications are provided by the school.
2. All OTC medication, including cough drops, must be in it's original, properly labeled container.
3. All prescription medication must be in its original container from the pharmacy with appropriate labels with student name and instructions for use.
4. I acknowledge that the school nurse or authorized district employees will administer the medication unless an Authorization for Self-Administration Form is completed.
5. I authorize the school to inform appropriate school employees who would have a need to know of the administration of medication.
6. I acknowledge and agree that the school shall secure (store) the medication for the student until administration of the medication is necessary unless an Authorization for Self-Administration Form is completed. **NOTE: All controlled medication will be stored and administered by school staff.**
7. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication. I hereby release the District and its employees and agents from liability for injury arising from the school's administration of the medication while on school property or at a school-related event.
8. In the event of a field trip, I understand that my child's medication will be sent with designated personnel (typically the teacher) in the amount to be administered during the activity unless otherwise specified by me.
9. I understand that I am responsible to pick up unused medication at the end of the year. If medication is not picked up by parent/guardian at the end of the school year it will be destroyed.

I am the parent/guardian of _____ and I authorize my child/ward, grade _____, to be administered the prescription/non-prescription medication identified below while on school property or at a school-related event or activity by the school nurse or employee trained in the administration of prescription medication.

Medication: _____

Dose: _____

Time/Circumstances to Administer: _____

Authorization start date: _____ end date: _____

Reason child is taking medication: _____

Precautions and reactions to observe and report: _____

Date	Parent/Guardian Signature	Phone #
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Reviewed 3/24/94
Amended 9/8/2014