MEDICATION: *Authorization/Request for Medication Administration in School*		**11/01/2005** **Revised : April 2017**

Please Note: This medication consent is effective for one school year and must be renewed annually.

(To be completed by Health Care Provider)

NAME OF STUDENT: _____ DOB: _____ SCHOOL: _____

MEDICATION: _____ DOSAGE: _____

TIME MEDICATION IS TO BE GIVEN: _____

TO BE GIVEN FROM (DATE) _____ TO _____

Significant Information: (include side effects, toxic reactions, omission reaction, contraindications):

If an emergency situation occurs during the school day or if the student becomes ill, school officials are to:

1. Contact me at my office _____
2. Take the child to the ER at _____
3. Other options: _____

EMERGENCY MEDICATIONS: Please complete if prescribing medications for Asthma, Anaphylactic, or Diabetic students!!

___ Yes ___ No ___ N/A Student may possess and self administer **ASTHMA** medications during the school day, at school sponsored activities, on the bus, or on other school property.

___ Yes ___ No ___ N/A Student may possess and self-administer an **EPI-PEN AUTO INJECTOR** during the school day, at School sponsored activities, on the bus, or on other school property.

___ Yes ___ No The student understands or has been instructed on self-administration of their emergency medication and Has demonstrated the skill level necessary to use the medication and any device necessary to administer the medication.

Physician's Signature: _____

Physician's phone: _____

DEA # _____Date:_____

Office Stamp:

(please)

To be Completed by the Parent/Guardian:

I hereby authorize the school nurse to confer with the licensed prescriber and correspond with the indicated agency regarding my child's health and treatment issues as they pertain to the medication/diagnosis and his/her attendance, education, and behavioral management. I understand that the medicine prescribed will be provided to the school in the original pharmacy labeled container with appropriate identifying information (name of child, medication dispensed, dosage prescribed, and the time it is to be given). If this is an over-the-counter product, the medication will be provided in the original container. I understand the medicine will be delivered to school personnel by a parent/guardian and that ***students are not to transport medications.*** *I hereby give permission for school staff (trained in medication administration) to administer the above named medication to my child according to the healthcare provider's directions. I hereby release the LEA and all its agents and employees from any and all liability that may result from my child taking a prescribed medication or for injuries arising from a student's possession or self-administration.*

Parent/Guardian Signature: _____ Phone: _____ Date: _____

School Nurse Signature: _____ Date: _____

Principal Signature: _____ Date: _____