# Consent and Release for Student to Carry Medication

Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The above-named student has been instructed in the proper purpose, appropriate method and frequency of use of (medication) .

The student will be permitted to carry this medication on his/her person. We, the undersigned absolve the School District of liability if the medication is lost, stolen or abused in any way by the student.

We further note that:

1. The above-named student understands his/her responsibilities for keeping the medication safely on his/her person. The above-named student understands the importance of preventing other students from using the medication, and that such use could seriously endanger other students. As a parent/guardian, I have discussed these issues with my child, and I believe he/she understands his/her responsibilities for safe medication use.
2. As a parent/guardian, I understand that as a result of losing his/her medication, my child is at risk for health complications that arise from not having the medication immediately available.
3. The student, parent/guardian and licensed healthcare provider understand that the usual policy of the Chandler School District is to keep all medications locked in the school health office, for the protection of all students.
4. I understand that the school is not responsible to assist, oversee or supervise my child in the administration of the medication.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Administrator Signature: Date:

District/School Nurse Signature: Date:

Licensed Healthcare Provider: Date: