OSSEO AREA SCHOOLS
ISD 279

Medication Administration Consent Form

Name of Student: _____ Birthdate: _____ ID #: _____

School: _____ School Year: _____ Grade: _____

Medical Condition	Medication	Dosage	Time	Route	Possible Side Effects
1. ICD 10 CODE:					
2. ICD 10 CODE:					
3. ICD 10 CODE:					

Other Considerations/Directions: _____

Start Date: _____ Stop Date: End of School Year- August 31st or Date: _____

_____ _____

(Print) Name of Physician/Licensed Prescriber Signature of Physician/Licensed Prescriber

_____ _____ _____

Clinic Address Phone Number Date

Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) to be given on field trips, as prescribed.
2. I release school personnel from liability in the event of adverse reactions resulting from taking the medication(s).
3. I will notify the school of any change in the medication(s), (example: dosage change, medication is discontinued, etc.)
4. I give permission for the nurse to communicate with the student's teachers about the student's health condition and the action of the medication(s).
5. I give permission for the nurse to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition being treated by the medication(s).
6. I give permission for the medication(s) to be given by designated personnel as delegated by the nurse.
7. I request that any remaining medication be sent home with the student on, or prior to the last day of school. I will notify the building nurse if the medication should not be sent home with the student.

Note: Medication is to be supplied in the original/prescription bottle.

_____ _____ _____ _____

Date Parent/Guardian Signature Telephone # Relationship to Student