

USD 373 – Newton Public Schools Health Services
REQUEST FOR PRESCRIPTION MEDICATION TO BE ADMINISTERED AT SCHOOL

Name: _____ School: _____ Grade: _____ Date: _____

Medication: _____

Dose: _____ Time: _____ Route: _____

Diagnosis/Reason for medication: _____

Licensed Health Care Provider Signature: _____
(M.D., D.O., D.D.S., A.R.N.P., or P.A.)

Printed Name of Licensed Health Care Provider: _____

PARENT/GUARDIAN PERMISSION TO ADMINISTER MEDICATION / INFORMATION EXCHANGE:

I hereby give my permission for _____ to take the above prescription at school as ordered.

I understand that it is my responsibility to furnish this medication. I understand that the medication is to be brought to school in the original container appropriately labeled by the pharmacy, or physician, stating the name of the medication, the dosage, and times it is to be administered. I understand the school policy regarding medication.

I further understand that any school employee who administers the medication to my child, in accordance with written instructions from the physician or dentist, shall not be liable for damages which might occur from an adverse medication reaction suffered by my child as a result of administering such medication.

I also give permission for the exchange of confidential health information between the school nurse, other representatives of my child's school, and the prescribing health care provider/pharmacy in the event a question or concern arises. I may revoke this consent to release information in writing and dated at any time except to the extent that action has been taken or information disclosed pursuant to signed consent. This consent shall remain in effect for a period of one year from signature date. To revoke this authorization, I should contact: my child's school. Once information is disclosed, it may no longer be subject to HIPAA protections.

Date: _____

Signature of Parent/Guardian