Parent/Guardian Consent for Medication Administration/Procedures
Verona Area School District

Student's Full Name:	**Date of Birth:**
Parent/Guardian Name:	**Daytime Phone Number:**

Non-Prescription / Over-the-Counter Medication

Non-prescription (over-the-counter) medication will only be administered upon receipt of parent/guardian written consent. Medication must be in the original container or packaging with the child's name written on the container and unexpired.

Medication	Dose	Time/Frequency	Start Date	End Date	Reason for Medication

Prescription Medication

Prescription medication will only be administered upon receipt of parent/guardian written consent **and** written instructions from the prescribing provider. Medications must be in the original pharmacy-labeled bottle, include the child's name, correct dosage, pill description, administration instructions, and be unexpired. If a medication order changes, I am responsible for providing a new properly labeled bottle.

Diagnosis:

Medication Name	Route / Dose	Frequency	Duration	Self-Administer?	Potential side effects to report?
			From: To:		
			From: To:		
			From: To:		
			From: To:		

Provider Name (Required):	**Phone Number:**
Clinic Name & Address (Required):	**Fax Number:**
Provider Signature (Required*):	**Date:**

** School nurse can fax prescription medication order request to the provider for signature.*

Signature required on opposite side of form.

Updated 5/2023

_____ I give my permission for school personnel to give my child the above medication(s) as directed.

All controlled substances (i.e. Ritalin, Adderall, methylphenidate, Ativan, Xanax) must be delivered directly to the school nurse or nurse designee. Any remaining controlled substances at the end of the school year, or when otherwise discontinued, must be picked up directly by the parent/guardian. Medication that is not picked up within the specified timeframe will be destroyed and discarded.

_____ I give my child (of any age) permission to carry and self-administer their ***rescue inhaler***. I understand self-administration is not supervised or verified by school staff. Approval to self-carry medication is at the discretion of the school nurse and self-carrying privileges may be revoked.

_____ I give my ***middle school / high school*** **child** permission to carry and self-administer the above medication(s). I understand parent/guardian written permission must be provided to the school nurse in order to carry and self-administer all medications, including non-prescription medications. Approval to carry medication is at the discretion of the school nurse and self-carrying privileges may be revoked. **Controlled substances cannot be self-carried or self-administered by students of any age.**

I agree to hold Verona Area School District, its employees and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of medication as described above at school. I hereby give permission to the school nurse to contact the prescribing provider as needed. I give consent for this information to be shared with relevant staff. I agree to contact the school nurse if any changes occur with the above request.

Parent/Guardian Signature: ____________________________ **Date**: _________________