Med Center Health

CONSENT FOR MEDICATIONS AND PROCEDURES

Student's Name _____ DOB: _____

School: _____ Date Form By the School: _____

Primary Care Provider: _____ PCP Phone: _____

I give permission for _____ to receive the medications and or procedures
Student's Name
below at school according to standard school policy and/or physician orders and expressly hold harmless and waive any liability on behalf of, the school or its employees and agents concerning any injuries from administration of the listed medications or procedures unless such is the result of negligence or misconduct on behalf of the school or its employees.

I understand that all medications are to be provided to the school and/or school nurse in the original container per Student Handbook policy on medications. A provider order will be needed in order for a student to be given medication or procedure at school.

Parent/Legal Guardian Signature: _____ Relationship: _____

Parent/Legal Guardian Printed Name: _____ Date: _____

Home Phone: _____ Work Phone: _____

Emergency Phone: _____

****TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER****

What Medications does this child need for school ?:

_____ Auvi-Q _____ Benadryl _____ EpiPen _____ EpiPen Jr.
_____ Diastat _____ Inhaler _____ Insulin Pen _____ Insulin Pump
_____ Glucagon _____ Insulin Syringe/Vial _____ Twinject _____ Nebulizer Medication
_____ Vagal Nerve Stimulator/Magnet _____ Other _____

Reason for medication: _____

Form of medication/treatment: ☐ Tablet/Capsule ☐ Liquid ☐ Injection ☐ Nebulizer ☐ Other _____

Instructions (Schedule and dose to be given at school): _____

Start: ☐ Date form received ☐ Other, as specified: _____
Stop: ☐ End of school year ☐ Other, date/duration: _____
☐ For episodic/emergency events only

Restrictions and/or important side effects: ☐ No restrictions ☐ Yes, please describe: _____

_____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other: _____

_____

Student has been trained and may carry and administer own emergency medication ☐ Yes ☐ No

**** Does this child require medications for sports, afterschool programs, and/or field trips per MD? __ Yes __No**

What procedures will this child need for school?:

_____ Catheterization _____ Tube Feeding _____ Seizure Monitoring
_____ Diabetic Care _____ Ostomy Care _____ Respiratory Monitoring
_____ Toilet Monitoring _____ Dressing Changes _____ Other: _____

Physician's Signature _____ Date _____ Time _____

Physician's Name _____ Phone _____

Address _____ Fax_____