KENNEDALE ISD
Committed to Excellence

Medication Consent Form

Parent/Guardian:

I hereby request that the following medication specified below be administered to my child. I understand and will comply with the school's policies and procedures regarding medication administration (policy included on the following page). I understand that unexpected consequences including, but not limited to, illness, adverse reactions or other complications may occur as a result of the administration (or non-administration) of any medication. The first time any medication is given; it must be administered at home by the parent to observe for any side effects. By requesting and consenting to the administration of medication to your child, you are assuming the risk of an unexpected reaction may occur and understand that Kennedale ISD and employees will not be held responsible.

Student Name: ______________________________ DOB: ____________ Campus/Grade: __________
Parent/Guardian's Name: ______________________________ Phone: ____________________
Email: ____
Date: ______________ Parent/Guardian's Signature: ______________________________

Student and parent are aware of the medication policies.

Diagnosis/Purpose of this medication: ______________________________
Any known allergies: [ ] NO [ ] YES Please list. ______________________________
Name of Medication: ______________________________ Strength (i.e. 10 mg/tab): ____________
Dose (i.e. # of tabs, tsp, oz, ml, puff): ____________________ Time (i.e. 11 am, lunch, PRN): ____________
Frequency (i.e. q 4 hrs): ____________ Duration (i.e. 10 days, school year): ____________________
Comments: ______________________________
Name/Strength of Medication Sent ____________________ Quantity Sent ________ Parent Initials ______

Is student authorized to carry the INHALER/EPI-PEN with them? **(RESCUE MEDS ONLY)** [ ] NO [ ] YES

<u>HEALTHCARE PROFESSIONAL SIGNATURE REQUIRED FOR</u>: **ALL** prescription medications and over-the-counter medications for grades Pre-K to 8th (parent signature for High School)

Healthcare Practitioner's PRINTED NAME: ______________________________
Healthcare Practitioner's Signature: ______________________________ Date: ____________
Office Phone: ______________________________ Office Fax: ______________________________

CAMPUS	Fax Number	CLINIC PHONE NUMBER
High School	817-563-3718	817-563-8120
Junior High	817-483-3655	817-563-8220
Delaney Elementary	817-483-3653	817-563-8420
Patterson Elementary	817-483-3638	817-563-8620
James A. Arther Early Childhood	817-483-3628	817-563-8320

FOR NURSE'S USE ONLY

504 _____ SPED _____ If so notify Diagnostician

Date Orders Rec'd __________ Date/Time Med Rec'd ____________ Medication Rec'd ______________ Quantity Rec'd ____

Lot # ____________ Expiration Date ______________ Nurse ______________________________

ALL Medications:

1. PARENT/GUARDIAN MUST SUPPLY ALL MEDICATIONS; SCHOOL PERSONNEL WILL NOT PROVIDE MEDICATION FOR ANY STUDENT
2. Medications **must** be in the ORIGINAL container and have a current label
3. Medications in baggies or combination of medications in the same bottle will not be accepted
4. The pharmacy will supply two bottles when requested one for home and one for school
5. "As needed"/PRN medications must also meet these requirements
6. Each medication must be on a separate form
7. Medications must be picked up by an adult and may not be transported home by the student. Medications left after the last day of school will be discarded and not be kept over the summer
8. Medication forms must be updated each school year
9. The school nurse cannot be expected to diagnose a condition or to select the correct medication to administer

PRESCRIPTION Medications:

1. Once or twice daily (every 12 hours) medications can be given before school and after school, three times a day (every 8 hours) medications can be given before school, after school and at bedtime and do not need to be given at school.
2. The requesting physician or dentist must state the dosage and reason for administering the medication.
3. Prescription medications must be kept in the clinic for administration by the nurse or another authorized district employee.
4. A medication administration form must be completed and signed by the parent AND physician.

OVER-THE-COUNTER/NON-PRESCRIPTION Medications:

A. Elementary and Intermediate Campuses
1. Medication must be kept in the school clinic for administration by the nurse or another authorized district employee.
2. A medication administration form must be completed and signed by the parent AND the physician.

B. Junior High Campus
1. Medication must be kept in the school clinic for administration by the nurse or another authorized district emplyee.
2. A medication administration form must be completed and signed by the parent AND the physician.

C. High School Campus
1. Medication must be kept in the school clinic for administration by the nurse or another authorized district employee.
2. A medication administration form must be completed and signed by the parent ONLY.

EXPIRATION DATES:

1. Expired medications will not be given
2. Check the date of expiration for inhalers and epi-pens and try to supply one that does not expire during the school year if possible.