*Revised: 5-11-15*

# SCHOOL CONSENT FORM FOR ADMINISTRATION OF MEDICATION

**(To be renewed annually)**

Student _____ Date of Birth _____

Parent/Guardian _____

School _____ Teacher/Grade _____

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## PHYSICIAN'S OR AUTHORIZED PRESCRIBER'S ORDER:

| | Medication | Dosage | Time | Start Date |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

Diagnosis/Medical reason for medicine:

_____ ICD-10-CM Code _____

_____ ICD-10-CM Code _____

Other recommendations/restrictions/unusual side effects: _____

The student is both capable and responsible for self-administering this medication
(Subject to school policy): _____ No _____ Yes, supervised _____ Yes, unsupervised

Physician's Signature _____ Date _____

Print Physician's Name _____ Phone No. _____

Clinic _____ Fax No. _____

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### PARENT/GUARDIAN AUTHORIZATION

1. I request that the above medication be given to my child during school hours as ordered by this student's health care provider (HCP). I understand I must provide prescription medications in an original pharmacy container with a current label. Over-the-counter preparations must be provided in the original, labeled container. A controlled prescription medication must be brought to school by a parent/guardian.
2. I give permission for a teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure.
3. I will immediately notify the school of any change in the medication or Health Care Provider's (HCP) order, dosage change, frequency, or duration of administration.
4. I give permission for this information to be released to school personnel. The information you provide will be shared only with staff in the school whose jobs require access to this information to ensure your child's safety and school success.
5. I understand that I can refuse to share this information with other school staff (contact school nurse).
6. I release all school personnel and the school district from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication.

_____ _____ _____

(Parent/Guardian Signature) Phone (Home) Date

_____

Phone (Work)