## Health Services – Medication Consent Form

**To be completed by Physician/Parent:**

Student Name: ___________________________________ D.O.B: _________________ Teacher/Grade: _____________

Name of medication (**one medication per consent form**): _______________________________________________

***Medication must be brought to school by the parent/guardian (students are not authorized to transport medication). Medication must be in the original container, labeled with child's name, and not expired.***

**Scheduled Medication:**

Dosage to be given: _______________________________ Time(s) to be given: ________________________________

Purpose of the scheduled medication: ____________________________________________________________________

**As Needed Medication:**

Dosage to be given: _______________________________ Time(s) to be given: ________________________________

Symptom for which medication may be given: ____________________________________________________________

**Self-Carry Medication: Student are only permitted to carry; Epi Pen, Insulin, Glucagon, pancreatic enzymes, and/or Emergency Inhaler. "Self-Carry Medication Authorization Form" must be completed, and submitted with "Medication Consent Form".**

***** All medications must be kept in the health room (except approved Self-Carry Meds)*****

**Physician's and Parent signature is required for ALL medication, prescription or over-the-counter.**

_____________________________________________ _____________________________________________
**Physician Name (Please Print)** **Physician Signature**

(______) ________________ (______) ________________ ____________________
**Physician Phone** **Physician Fax** **Date**

I hereby give permission for my child, named above, to receive medication during school hours, during the after school program, during athletic events or practices, and during field trips. I also give the school nurse or athletic trainer permission to contact the prescribing physician with any questions or concerns. I hereby release Union Academy and their agents from all liability that may result from my child taking this medication.

_____________________________________________ (______) ________________ ____________________
**Parent/Legal Guardian Signature** **Daytime Phone** **Date**

**Medication Picked up**

Parent/Guardian Signature: ____________________________ Date: _______

**Medication Discarded**

Amount:_____________ Nurse Signature: ____________________________ Date: ______

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## Health Services Department –
## Student Self-Carry Medication Authorization Form
## Emergency Medications

Student Name: ________________________________________________ Date of Birth: ________________________

Medication: _____________________________________________ Administer For: ____________________________

**This form is for students with asthma, diabetes and/or severe allergies who may require emergency rescue medications (inhaler, insulin, glucagon, pancreatic enzymes or epi-pen).**

**Healthcare Provider:** This student is capable of and has been instructed on how to self-administer this medication as directed on the medication consent form (both correct technique and dose intervals). Please allow him/her to self-administer it during school hours or activities.

This student will not require adult supervision while taking this medication.

**Healthcare Provider Signature:** _____________________________________________ **Date:** __________________

**Parent/Guardian:** I give consent to Union Academy Charter School to allow my child to self-administer this medicine at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medicine. I absolve the Union Academy School Board and their agents from any and all liability whatsoever that may result from my child taking this medicine at school.

**Parent/Guardian Signature:** ________________________________________________ **Date:** __________________

**Student:** I am capable of taking this medicine as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to disciplinary actions if medications are shared. I will inform an adult when the emergency medication is used.

**Student Signature:** _______________________________________________________ **Date:** __________________

**School Nurse:** I have reviewed this request and agree that this student should be capable of safely self-administering this medication.

**Union Academy Nurse Signature:** ___________________________________________ **Date:** __________________

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