

Westbrook Walnut Grove School ISD 2898



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Consent for Medication Administration

Student: _____ Date of Birth: _____

Grade/Teacher: _____

Medication(s):

Name	Dosage	Route	Time	Diagnosis

Physician Name/Signature: _____ Date: _____

Clinic Affiliation: _____ Phone # _____

Parent/Guardian Authorization:

1. I request that the above medication(s) be administered to my child during school hours as ordered by their health care provider. I understand that these medications must be provided in an original pharmacy container with a current label. Over-the counter medications must be provided in the original container.
2. I give permission for a teacher/responsible adult to administer the medication to my child on a field trip as needed.
3. I will immediately notify the school of any change in medication orders from the child's prescriber.
4. I understand that this information will be released to school personnel as needed to provide the best coordinated care for my child.
5. I release the school district and all personnel working on behalf of the district from any and all liability in the event of an adverse reaction resulting from the administration of the listed medication(s).

Parent/Guardian Name(Print): _____

Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Kyle Jans, RN BSN
 WWG School Nurse

Westbrook Walnut Grove School is an Equal Opportunity Employer