BILLINGS PUBLIC SCHOOLS
Inspire Educate Empower

REQUEST FOR ADMINISTRATION OF MEDICATION/PROCEDURE
PARENT/GUARDIAN CONSENT FORM

NAME OF STUDENT: _____DOB _____ SCHOOL YEAR: _____
BEGINNING DATE: _____ SCHOOL:_____ Grade: _____

This form provides authorization from the health care provider and the parent/guardian for the following medical treatment to be provided during school hours. The document must be completed and signed by the prescribing health care provider and the parent/guardian BEFORE the procedure can be done in the school.

PHYSICIAN'S ORDERS FOR MEDICATION/PROCEDURE

(To Be Filled Out By Doctor's Office)

The following medication/procedure has been prescribed by me and is necessary for
_____to take during school hours.
(Child's Name)

Med Name or Procedure	Dosage	Time	Physician	Diagnosis	ICD-10 Code

_____
(**Physician's Signature**) (Date)

Please Initial the following options :

MEDICATION/PROCEDURE TO BE GIVEN/PERFORMED ON EARLY OUT DAYS:_____YES_____NO

MEDICATION ON A FIELD TRIP WILL BE (Parent and MD Please initial one of the following)

1) Omitted that day: Parent _____ Physician_____
2) Given before field trip or on return: Parent_____ Physician_____
3) Must be given as ordered, cannot be altered: Parent_____ Physician_____

- **I request that the School Nurse or LPN administer the medication listed above.**
- **I understand that I need to have a Physician's Order signed by the Doctor annually BEFORE the medication or procedure can be done in the school.**
- **I understand that the first dose of any new medication needs to be given at home.**
- **I understand a new form must be completed when there is a change to the order.**
- **By signing this document, I give permission for this Health Care Provider to share information about this medication/procedure with the Registered Nurse or LPN**
- Medication must be furnished in a current original pharmacy container with student's name, name of medication, strength, and dosage to be given.
- When there is a change in medication or dosage, a new labeled container from the pharmacy indicating the new dose/time is also required. (Also new parent request/signatures)
- Non- prescription medication must be furnished in the original container from the manufacturer.
- I acknowledge that the school district may not incur liability as a result of any injury arising from the administration of medication and that the parent shall indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on an act of omission, that is the result of gross negligence, willful and wanton conduct, or an intentional tort.

IS CHILD TAKING ANY OTHER MEDICATION AT HOME? : _____ YES _____ NO
NAME OF OTHER MEDICATION: _____

_____
Signature of Parent/Guardian **Date** **Phone**

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