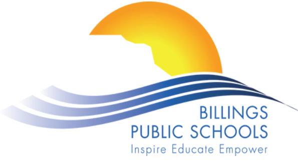

Billings Public Schools
Parent Consent for STUDENT SELF-ADMINISTRATION of MEDICATION

Name of Student:______________________ DOB:_________ School: _______________ Grade:______

I request that my child be allowed to self-administer medication during school hours in the presence of school personnel. I have read and agree to the following conditions:

- Medication will be taken by a student at school only when absolutely necessary. Whenever possible, schedule medication outside of school hours.
- My child has been instructed in and understands the purpose, appropriate method, frequency, and use of his/her medication.
- My child understands that he/she is not to allow anyone else to use his/her medication.
- I understand that I need to complete this consent form and have it signed by my child's Health Care Provider for all prescription medication and in accordance with district policy BEFORE the medication can be taken at school. This form must be updated yearly and any time there is a change in the medication, dose, or timing of medication.
- I understand that the first dose of any new medication must be given at home in accordance with district policy.
- By signing this document, I give permission for this Health Care Provider to share information about this medication with the Registered Nurse.
- Prescription medication must be furnished in a current original pharmacy container with the student's name, name of medication, strength, and dosage to be given. Non-prescription medication must be furnished in the original container from the manufacturer.
- I am responsible for transportation of medication to and from school and ensuring that my child has an adequate supply of necessary medication. I understand that it is my responsibility to pick up any unused medication at the end of the school year, and that medication not picked up will be disposed of.
- I acknowledge that the school district may not incur liability as a result of any injury arising from the self-administration of medication by the student and that I shall indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on an act or omission that is the result of gross negligence, willful and wanton conduct, or an intentional tort.

Is your child taking any other medication at home?
If yes, please list name of other medication(s):____

Parent/Guardian Signature:___________________________Date:____________Phone:___________________

Non-prescription/Over the counter medication	Dosage	Condition/When to take

PHYSICIAN'S ORDERS FOR SELF-ADMINISTRATION OF MEDICATION AT SCHOOL

***Required for all prescription medication and as requested by the School Nurse for non-prescription medication.**

I certify that valid health reasons exist requiring said student to have this medication during school hours. I confirm that this student has been instructed in the proper use of this medication and is able to self-administer this medication in the presence of school personnel:

PRESCRIBED MEDICATION	DOSAGE	TIME	DIAGNOSIS	PHYSICIAN

Physician's Signature:____Date:_____________________

Revised 4/5/2022 RC RN