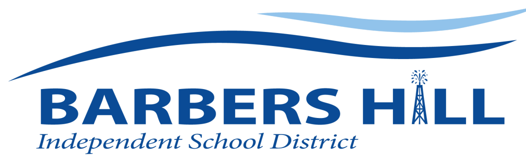


# Medical Consent Form for Medication Administration
# 2024-25

I request that designated Barbers Hill ISD personnel administer the medication listed below to my child according to the physician/prescribing healthcare provider instructions. I agree to provide any and all medication in compliance with the medication protocols. This form is valid for the 2024-25 school year only.

## PHYSICIAN/PRESCRIBING HEALTHCARE PROVIDER AUTHORIZATION

**MEDICATION INFORMATION BELOW MUST BE COMPLETED BY PHYSICIAN/PROVIDER**

**Name of Student:________________________________DOB: ______________ Grade: _________**

**Condition for which the medication is administered: _____________________________________**

**Name of medication: ____________________________ Dose: _____________Method:__________**

**Frequency: ____________________________________ Medication expiration date:___________**

**Side effects to be noted/reported:__________________________________________________**

***Please check:***

**____Duration (dates) of administration: Begin _________End: ________** ***(Limit of one school year)***

**____ Duration of school year (2024-25)**

___________________________ ______________________ _______________ ____________

***Physician Signature*** ***Print Name*** ***Phone*** ***Date***

## PARENT/GUARDIAN AUTHORIZATION

**By signing below, I acknowledge that:**

1. I give permission for the designated Barbers Hill ISD personnel to administer this medication in accordance with the physician's instructions above.
2. I give permission for the school to contact the above health care provider about the administration of this medication.
3. I understand that the school district, Board of Trustees and its employees shall be immune from civil liability due to allergic reaction or other injuries resulting from the administration of medication to a student, provided such administration conforms to the requirements of this policy.
4. Elementary and Intermediate students are **NOT** permitted to transport medication to and from school.
5. Unused medications not picked up within 5 days of being discontinued or at the end of the school year will be disposed of properly.

_____________________________ ___________________________ __________________

*Parent/Guardian Name (Print)* *Parent/Guardian Signature* *Date*