Consent/Release Forms (Medications) Prescription or Over-the-Counter Medication at School

SCHOOL: _____ This information is valid for current school year only. **SCHOOL YEAR:** _____

If medication administration is required during the school day, this form must be completed. Emergency Medication Consent is on IHP forms. All medications are kept in the health unit, unless otherwise ordered by the physician, and must be in the original container with original label. For Rx medication, the pharmacy label must match the directions on this form. The initial dose of a medication cannot be administered at school.

When deemed responsible to carry and or self administer medication by his/her health care provider, Montgomery County Schools shall permit, but reserves the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event.

NAME: _____ DATE OF BIRTH: _____ GRADE: ____ALLERGIES: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER & PARENT/GUARDIAN

(1) Medication: _____ Dosage: _____ Directions: _____

Administration Time: ☐ Lunch or ☐ _____ Route: _____

Diagnosis/Condition: _____

Possible Side Effects: _____ Duration: Start_____ Stop_____

The student has received training to carry this medication and, in my opinion, may:

☐ CARRY and/or ☐ SELF ADMINISTER this medication. Physician's Initial_____ Parent/Guardian Initial _____

(2) Medication: _____ Dosage: _____ Directions: _____

Administration Time: ☐ Lunch or ☐ _____ Route: _____

Possible Side Effects: _____ Duration: Start_____ Stop_____

The student has received training to carry this medication and, in my opinion, may:

☐ CARRY and/or ☐ SELF ADMINISTER this medication. Physician's Initial_____ Parent/Guardian Initial _____

(3) Medication: _____ Dosage: _____ Directions: _____

Administration Time: ☐ Lunch or ☐ _____ Route: _____

Possible Side Effects: _____ Duration: Start_____ Stop_____

The student has received training to carry this medication and, in my opinion, may:

☐ CARRY and/or ☐ SELF ADMINISTER this medication. Physician's Initial_____ Parent/Guardian Initial _____

I am the parent/guardian of the above named student and give consent and permission for the information on this form to be shared with teachers, principals, and other school personnel that have direct contact with my child for the current school year. During school hours, I understand teachers, assistants, nurses or other trained school personnel may be administering these medications according to the specified physician's order and District policy. The student has the ultimate responsibility of reporting daily for their medication. I agree to provide the necessary medication or treatment supplies and agree to notify the school nurse immediately of any changes. The school nurse shall contact the health care provider to obtain current information when necessary to manage the student's condition at school. I understand that the Montgomery County Board of Education Medication Policy and Procedures (09.2241) are readily available for me to read.

I give permission for the storage and administration of this/these medication by trained school personnel accompanying my student on a field trip or school related function in Kentucky and/or other states. I hereby release the Montgomery County Board of Education and its employees from any claims or liabilities connected with their reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance.

Parent's Signature _____ Parent's Phone _____ Date _____

*Physician's Signature_____ Physician's Phone _____ Date _____

Physician Printed Name: _____ Fax Number: _____