Benson Public Schools
Consent for Prescription Medication

Student _____ Date of Birth_____

Grade/Teacher _____ School Year _____

Physician's or Authorized Prescriber's Order

Medication _____ Dosage _____

Time of administration _____ Diagnosis (ICD-10-CM if known) _____

Start Date _____ Stop Date _____ □ End of School Year

Other recommendations/restrictions/unusual side effects _____

This student is both capable and responsible for self-administering this medication (subject to school policy)

□ No □ Yes-supervised □ Yes- unsupervised

Prescriber's Signature _____Date _____

Print Name _____ Clinic_____

Parent/Guardian Authorization

I request that the above medication be given during school hours as ordered. I understand that I must provide this medication in the original pharmacy container with a current label. All scheduled medication must be delivered by an adult & cannot be sent with a student. I will immediately notify the school of any changes in the medication order. I give permission for this information to be released to school personnel. The information you provide will be shared only with staff in the school whose jobs require the information to ensure your child's safety. I understand that I can refuse to share this information with other school staff (contact school nurse). I give permission for the school to release and exchange information with the above health care provider. I release the school personnel and the school district from any and all liability in the event of any adverse reaction resulting from the use or administration of this medication. I understand the school will not assume responsibility for medications that are self-administered.

It is the parent/guardian responsibility to: replace expired medication, provide refills when needs & transport the medication to school. Unused medication may be picked up by a parent/guardian at any time. Medication remaining at the end of the school year will be properly discarded. Medication will not be sent home with students without parent/guardian permission.

1. This medication should be sent on field trips and I give permission for a teacher/responsible adult to administer the medication. ☐ Yes ☐ No
2. This medication should be given on 2 hours late or early out days ☐ Yes ☐ No (will be done at home)

Parent/Guardian Signature _____ Date _____