MEDICATION CONSENT FORM/RELEASE OF INFORMATION

Today's Date: _____

Student's Name: _____ Age: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher/Advisor/Homeroom: _____

PARENT/GUARDIAN AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL 8 AM-3:30 PM:

I request that the medication described below, in the original container, be administered to my child during the school day. I understand that a licensed school nurse or a trained unlicensed school personnel will be performing this service utilizing the order provided by my child's physician or licensed health care provider. I acknowledge that the School District and its employees and agents shall incur no liability as a result of administration of this medication to my child and agree to indemnify and hold harmless the School District and its employees and agents from legal fees, costs. And any potential damages arising from medication administration. I give the school nurse permission to contact the physician, health care provider and/or pharmacist with any questions concerning the medication. I understand and agree that it is my responsibility to resupply the medication when the initial supply has been depleted. I also understand that I am responsible for providing a school medication consent form that is signed by my child's provider.

Medication Strength #Amount to be given Time to be given

_____

_____

_____ _____
Signature of Parent/Guardian Date

_____ _____
Print Name Daytime Phone Number

INITIAL MEDICATION SUPPLY

_____ # of Pills/Tablets/Capsules/ML_____
Name of Medication

_____ _____
Nurse Signature Date