Medication Form

NOTE: A separate form must be completed for each medication administered

Student's Name _____ Date of Birth _____ Grade ___

The school nurse (or designee) has my permission to take a photograph of my student for identity purposes.

Signature of Parent/Guardian _____ Date _____

Name of Medication _____ Dosage _____

Time to be taken _____ Ordering Physician _____

Reason for Medication _____

In case of an Emergency, call _____

I certify that ***at least one*** dose of the medication has ***previously been given*** and **NO** adverse reactions were experienced. Therefore, I give permission for the school nurse (or designee) to administer the above medication to my child.

For an oral controlled substance, in the unavailability of a school nurse, ***the parent may delegate*** to the following designee, _____ to administer the medication at school.

I acknowledge that the District, its Board of Directors, and its employees shall be immune from civil liability for damages resulting from the administration of medications in accordance with this consent form.

_____ _____

Parent or Guardian Date

Note: Medication **MUST BE** in current original container from the pharmacy. The medication will only be administered according to the physician's directions on the container.

Date	Pill Count	Brought by	Signature/Signature (two persons)	Comments