ADMINISTRATION OF MEDICATIONS TO LEARNERS CONSENT FORM

Name of Learner: ____________________________________ D.O.B.: ___________________

Parent/Guardian Name: ____

Telephone: _______________________ School: ____________________________________

Medication/Treatment	**Dosage**	**Route of Administration** *(i.e. oral, topical, etc)*	**Time(s) to be administered at school**	**Authorization Start Date** *(month/day/year)*	**Authorization End Date** *(month/day/year)*	**Precautions & reactions to observe**

Option I: _______ (parent initials)
I authorize the school nurse or trained personnel at the above-named school to administer the medication/treatment described on this form to the above-named learners. I understand the medication must be provided in the original properly labeled container. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication. I give permission for communication that may be necessary between the prescribing provider and the school nurse to ensure safe medication or treatment administration for the above-named learners.

Option II: _______ (parent initials)
I certify the above-named learner is capable of carrying and self-administering the above medication. I understand that the school district and individuals involved will not be held liable for any adverse effects of the medication. I understand this option is available only when it will not be a potential health risk to the above-named learner or others. I give permission for communication that may be necessary between the prescribing provider and the school nurse to ensure safe medication or treatment administration for the above-named learner. I understand the above-named learner's possession is limited to the dose necessary during the school hours or event for one day.

____ ____________________________

Parent/Guardian Signature Date

1. ~~I am the parent/guardian of ____________________________________ and I authorize my child/ward _________________________________, grade ________, to be administered the prescription/nonprescription medication identified below while on school property or at a school-related event or activity by the school nurse or employee trained in the administration of prescription medication.~~

2. ~~I hereby release the District and its employees and agents from liability for injury arising from the school's administration of the medication while on school property or at a school-related event.~~

3. ~~I understand that if the learner identified herein uses the medication in a manner other than prescribed, the learner may be subject to disciplinary action by the school, however, any disciplinary action may not limit or restrict the learner's immediate access to the medication.~~

4. ~~I authorize the school to inform appropriate school employees who would have a need to know of the administration of medication (i.e., such as school nurses, instructors, teacher aides, school administrators, activity supervisors, bus drivers).~~

5. ~~I acknowledge and agree that the school shall secure (store) the medication for the learner until administration of the medication is necessary, and that in no circumstances shall the medication be stored in the learner's locker.~~

~~Medication:~~
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~~Dose:~~
____

~~Time:~~
____

~~Authorization Start Date:~~
____

~~Authorization End Date:~~

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~~Date   Printed Name of Parent/Guardian   Signature of Parent/Guardian~~