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