| School Consent Form for Administration of Medication - Renville County West ISD #2890 | | | |
|---|---|---|---|
| Student: | | Date of Birth: | |
| Parent/Guardian: | | | |
| School: | | Teacher/Grade: | |

| Physician's or Authorized Prescriber's Order | | | |
|---|---|---|---|
| Medication | Dosage | Time | Start Date |
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|---|---|---|---|
| Diagnosis/Medical Reason for Medicine: | | | |
| Other Recommendations/Restrictions/Unusual Side Effects: | | | |
| This student is both capable and responsible for self-administering this medication (subject to school policy, check all that apply): | | | |
| | Yes, Supervised | | |
| | Yes, Unsupervised | | |
| | No | | |
| Physician's Signature: | | Date: | |
| Print Physician's Name: | | Phone Number: | |
| Clinic: | | Fax | |

| Parent/Guardian Authorization |
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| 1. I request that the above medication be given to my child during school hours as ordered by myself or by this student's Health Care Provider (HCP). I understand I must provide prescription medications in an original pharmacy container with a current label. Over-the-counter prescriptions must be provided in the original, labeled container. A controlled prescription medication must be brought to the school by a Parent/Guardian. |
| 2. I give permission for a teacher/responsible adult to administer the medication on a field trip, as necessary, following school procedure. |
| 3. I will immediately notify the school of any changes in the medication or HCP's order, dosage, frequency, or duration of administration. |
| 4. I give permission for this information to be released to school personnel. The information you provide will be shared only with the staff in the school whose jobs require access to this information to ensure your child's safety and school success. |
| 5. I understand that I can refuse to share this information with other school staff (contact school nurse). |
| 6. I release all 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. |

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| Parent/Guardian Signature and Date: | Phone # (Work): | |
| | Phone # (Home): | |