School Consent Form for Administration of Medication
New London-Spicer Public Schools

(TO BE RENEWED ANNUALLY)

Student _____ Date of Birth _____ Grade _____

Parent/Guardian's Names _____

Physician's or Authorized Prescriber's Order- Please Complete

(Physicians Signature is NOT required for Over the Counter Medications)

	MEDICATION:	DOSAGE:	ROUTE:	TIME:	MEDICAL CONDITION:
1.					
2.					
3.					
4.					
5.					

Inhaler:

- ☐ Student may carry/self administer his/her inhaler according to the licensed prescriber's instructions. This student has been instructed on proper use, side effects, and safeguards regarding this medication.
- ☐ It is my professional opinion that this student **should not carry** his/her inhaled medication.

Epi-pen:

- ☐ Student may carry/self administer his/her Epi-Pen/auto-injector according to the licensed prescriber's instructions. This student has been instructed on proper use, side effects, and safeguards regarding this medication.
- ☐ It is my professional opinion that this student **should not carry** his/her Epi-pen/auto-injector.

Other:

- ☐ Student may carry/self administer _____ (Please identify).

_____ _____ _____

Print Name of Physician/ Licensed Prescriber | Physician/ Licensed Prescriber Signature | Date

_____ _____ _____

Clinic Name /Address | Clinic Phone Number | Clinic Fax Number

Please fax this form to my student's school nurse. Fax Number: _____

Parent/Guardian Authorization

1. I request that the above medication be given to my child during school hours as ordered 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 preparations must be provided in the original, labeled container. A *controlled prescription medication* must be brought to 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. Only daily medications and those for life threatening/emergency conditions will be sent on field trips.
3. I will immediately notify the school of any change in the medication or Health Care Provider's (HCP) order, dosage change, 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 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 understand that school health personnel cannot administer the medication(s)/treatment(s)/procedure(s) indicated on this form without authorization from my student's physician/licensed prescriber.
7. All medication will be stored in the Health Office and administered by designated school personnel. (Exceptions to this requirement: asthma medications, EpiPens and nonprescription Acetaminophen and Ibuprofen for High School students).
8. Students are allowed to carry and self-administer asthma medications and EpiPens according to the school policy. See medication policy for specific guidelines. Policy available upon request.
9. 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.

_____ _____ _____

(Parent/Guardian Signature) (Relationship to student) (Date)

Parent Phone Numbers: _____ _____

To Be Completed by Parent/Guardian

I, request and authorize my child _____ to carry and/or self-administer their medication _____.

This authorization is given and based on the following: I understand that my child shall be permitted to carry at all times their medication as long as they do not endanger him/herself or other persons, and will not misuse the medication. I understand that if my child misuses by not taking the prescribed dosage, or endangers others with the medication, school employees or agents may confiscate the medication. I understand that this authorization shall be effective for this current school year and must be renewed annually. I hereby give my permission for my child to self-administer medication at school as prescribed by my child's prescribing health professional and I authorize reciprocal release of information related to my child's health/medications between the building nurse and the prescribing health professional/clinic.

_____ _____

Signature of parent/guardian Date

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Prairie Woods Elementary: Ext. 2360
Middle School/High School: Ext. 2404
District Nurse: Ext. 2612