USD 247 SOUTHEAST
CONSENT FOR PRESCRIPTION MEDICATION AT SCHOOL

AUTHORIZATION FOR MEDICATION TO BE ADMINISTERED AT SCHOOL AND FIELD TRIPS

Part A - **Parent** to Complete

Name of Student _____ Date of Birth _____

Grade _____ Teacher _____

I grant permission for the school nurse or a delegated staff member to administer medication/treatment to my child at school as indicated by my child's physician accordingly below. I understand that I must provide any prescribed medication in its original labeled container. The dosage, date and time must be clearly labeled on the original container. You may ask for two containers, one for home and one for the school. I also acknowledge the need and give permission for appropriate communications between the school health professional and the medical prescriber. *In order to avoid unexpected allergic reactions in the school setting, the first dose of the prescribed medication must be given at home.

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By signing this form I am consenting for USD 247 to administer the following medication to my child. I verify that the first dose of this medication was given at home. I further understand that any school employee who gives the above medication to my child shall not be liable for damages as a result of an adverse reaction suffered by my child as a result of giving this medication.

_____ _____ _____

Parent Signature Parent (Printed Name) Date

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Part B - **Physician** to Complete

Current Diagnosis _____

PHYSICIAN MEDICATION AND/OR TREATMENT ORDERS: (PLEASE SPECIFY)

Medication/Treatment _____

_____

Dosage _____ Time/Frequency _____

Special Instructions _____

_____

_____ _____ _____

Physician Signature Physician (Printed Name) Date

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Physician Phone Number
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