

MSD of Shakamak
Consent for Medication Administration at School

Parents of students requesting that medication or treatment be administered during school hours by school staff are required to provide for the school: (1) The physician's order (2) this completed parental release and (3) the medication in the original, prescription bottle.

STUDENT NAME _____ GRADE _____

Medication or Treatment _____

Dosage and Time of Administration _____

Purpose or condition for which prescribed _____

Remarks _____

Physician _____

Authorization for Self-Administration

I authorize that the above named student has an acute or chronic medical condition for which I have prescribed this medication. The student has been instructed on how to properly self-administer this medication. The nature of the condition requires the medication be available for "EMERGENCY" administration. I authorize that the student is responsible to use the medication appropriately and meets these criteria.

Physician Signature _____ Date _____

PARENTAL RELEASE FOR MEDICATION ADMINISTRATION

I request that the above named medication/treatment be administered to my child as prescribed by the physician. I understand that I must provide the medication in the original bottle, properly labeled by the pharmacy with the student's name, date, dosage, time, and directions for administration. I agree to notify the school immediately of any change/circumstance concerning the administration of this medication. I release school personnel from any liability in relation to the administration of this medication or treatment in school.

Parent/Guardian Signature _____ Date _____

School Nurse Signature _____ Date _____