Medication Consent Form

We attempt to discourage administration of medication in the schools. However, if your physician and you decide it is necessary for your child to receive a medication during the school day and you are unable to make other arrangements, specific directions must be provided for school personnel to give the medication.

Please take this form to your physician and have him/her record the necessary information regarding the administration of your child's medication.

_____  _____

- ❑ Routine Order
- ❑ PRN Order

To be completed by Physician, Physician Assistant, or Nurse Practitioner

Name of Student _____ Name of Drug_____
Dose _____
Time and/or circumstance of administration at school _____
_____
Can a reaction be expected? _____ If so, describe _____
_____
What should be done? _____
How long is medication to be continued? _____

SELF-ADMINISTRATION OF PRESCRIPTION ANAPHYLAXIS AND ASTHMA MEDICATIONS:

Please check one

□ I have instructed the above named student in the proper way to use his/her medication. It is my professional opinion that he/she should be allowed to carry and self-administer this medication while on school property or at school-related events.

□ It is my professional opinion that the above named student should **NOT** be allowed to carry and self-administer any of his/her anaphylaxis or asthma medications while on school property or at school related events.

_____ _____
Physician's Signature Date Physician's Phone number

To be completed by Parent

I request that school personnel administer the above stated medication to my child during school hours. I hereby release Red Lick Independent School District and employees of the district from any liability due to any allergic reactions or adverse side effects of the drug.

_____
Parent/Guardian Signature Date