VEGA ISD MEDICATION CONSENT FORM

This form must accompany all medications before administration. Non-Prescription medication must be in the original container and prescription medication must have a pharmacy label for the child. All medications must comply with FFAC (LOCAL) policy.

Student Name: _____ Grade Level: _____

Drug Allergies:_____ Date of Birth:_____

Parent Name/Phone:_____

Name of Physician/Healthcare Provider _____

Medical Diagnosis (if applicable)_____

MEDICATION TO BE GIVEN: _____

Reason for Medication:_____

Type of Medication

- ❑ Prescription
- ❑ Non-Prescription (Over the Counter)

Instructions (Schedule and dose to be given at school)

Dose to be given:_____

Form of medication/Treatment: (circle)

Tablet/Capsule Liquid Inhaler Injection Nebulizer

Spray/Cream or lotion Other:_____

Time to be given (specific time or as needed)**:**_____

- ❑ **PRN *(as needed)* Medication may be given how often:**_____
- ❑ **If PRN, under what circumstances should the medication be administered:**

  _____
- ❑ **Please call parent every time medication is given**

Duration: Medication to begin on: _____ Ends on:_____

Special Handling instructions: Refrigeration _____ Keep out of sunlight_____

Restrictions and/or important side effects:

- ❑ None anticipated
- ❑ Yes If Yes, please describe:_____

Please note a physician order must accompany all prescription meds or over-the-counter meds to be taken daily over 15 days, or it will not be given. (Or a physician signature below). Physician note not required for non-prescription medications only to be given on an as needed basis during the school year unless the medication contains aspirin.

_____ _____ _____

Physician Name (*printed*) Physician Signature Date

PARENTS REQUEST AND RELEASE FOR ADMINISTRATION OF MEDICATION

I request and authorize designated school personnel to give the above medication to my child (named above). I hereby acknowledge that I have read and understand the regulations for medication administration as adopted by Vega ISD. I hereby release Vega ISD and its employees from any claims or liabilities connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the above licensed prescriber or other Vega ISD staff as necessary for the care of my child. I authorize that my child's physician or health provider may release private medical information regarding the above medical condition or medication, for the proper treatment and care of my child while at school.

_____ _____

Parent/Guardian Signature Date