ROSENDALE-BRANDON SCHOOL DISTRICT

MEDICATION CONSENT FORM AND ADMINISTRATION RECORD

Full name of child to be medicated _____ DOB _____ Grade _____

Name of non-prescription medication(s) _____

Reason for medication _____

Hour(s) medication is to be given _____ # of days _____

Other Medications being taken by child _____

Name of person(s) who will be giving medication during school hours _____
(to be filled out by school nurse or principal).

******* This section to be filled out by physician for prescription medication only; Daily Medications and P.R.N. Medications (as needed) *******

Medicine	Route	Dose	Time to be given	Date range	Condition for which medication is to be given	Possible adverse reactions to medication (if none, so state)

Plan for teaching self administration, if appropriate: _____

I agree to retain the power to direct, supervise, decide, inspect and oversee the administration of such medication(s). Direct contact shall be made with me at any time should you have any questions or observe adverse reactions.

Hospital/Clinic/Office _____

Address _____ Phone _____

Physician's signature _____ Date _____

FOR ALL MEDICATIONS

I hereby give permission to the above named persons to give the medication(s) to my child/ward according to the directions stated above, and further authorize them to contact the child's/ward's physician. I understand that other school personnel may need to be informed of my child's need for medications and possible side effects of the medications. I agree that the school district, its employees and agents who act within the consent granted by this document, shall not be liable for any claims that I may have arising from the administration of this medication to my child/ward, and further agree to hold the school district, its employees and agents, harmless against any claims that may be brought against them arising from the administration of this medication at school while such administration is being done in conformity with this document.

I agree to notify the school in writing at the termination of this request or when any change to the above order is necessary.

Parent/Legal Guardian Signature _____ Date _____

Home Phone _____ Cell Phone _____ Work Phone _____

NURSES' COMMENTS:

☐ Provisions have been made for field trips

Medication	Date	Time	Initials

Medication	Date	Time	Initials