

**BIG HOLLOW SCHOOL DISTRICT #38**

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Big Hollow Primary School (K-1)  
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**MEDICATION ADMINISTRATION CONSENT FORM**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ School Year: \_\_\_\_\_

Only medications that are absolutely necessary for the student to take in order to complete the school day will be administered during school hours. District policy states that prescription and over-the-counter medications may be administered only upon written request of both the student's physician and parent/guardian. All medications must be brought to and from the school by the parent/guardian in the original container labeled with the student's name, date of birth, and dosage instructions. This form must be completed and returned to the nurse's office before medication can be taken. **This is the only acceptable form.** The school must be notified in writing of any changes. The school district retains the discretion to reject requests for self-administration of medications.

My child requires medication that must be taken during school hours. I authorize the school to supervise the administration of this medication in accordance with the physician's directions. I understand that my signature on this form constitutes a waiver by me to the staff, school district, its board and members, and other school personnel for liability for unexpected reactions when the medication is administered as ordered.

**I have read and consent to the school medication administration policy.**

\_\_\_\_\_  
*Signature of Parent/Guardian* *Date* *Emergency Phone Number*

**\*\*Only one medication per form\*\***

**PHYSICIAN'S ORDER AND AUTHORIZATION/CAREPLAN**

Student's Name: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dose: \_\_\_\_\_

Route: \_\_\_\_\_ Frequency: \_\_\_\_\_ Length of Time Required: \_\_\_\_\_  
*(i.e. # of Days, Entire School Year)*

Diagnosis for which the Medication is Prescribed: \_\_\_\_\_

Expected therapeutic effects of medication: \_\_\_\_\_

Possible Side Effects: \_\_\_\_\_

Please check the following box only for students with inhalers, epinephrine pens, or insulin.

**All other medication must be stored in the nurse's office.**

I certify that the above named student has been instructed in the use and self-administration of this medication. He/She understands the need for the administration of this medication. He/She understands the need for the medication and the necessity to report to school personnel any unusual side effects. He/She is capable of using this medication properly and possessing it at school. I may be reached at the following phone number in the event of an emergency.

Note: If any medications, testing supplies, etc. are found not disposed of properly, students may lose the privilege of carrying the medication themselves.

\_\_\_\_\_  
*Print Name of Physician* *Telephone Number*

\_\_\_\_\_  
*Signature of Physician* *Date*