

North Mahaska Community School District Medication Consent Form

Student's Name _____ Date of Birth ____/____/____
School _____ Grade/Teacher _____

School medications and health care services are administered following these guidelines:

- Parent signed and dated authorization to administer the medication.
- The medication is in the original labeled container as dispensed, or
- The medication is in the manufacturer's labeled container.
- The medication label contains the student's name, name of medication, directions for use and date.
- Authorization is renewed annually and immediately if the parent notifies the school nurse that changes are necessary.

****Any change in the prescription (dosage, time, etc.) must be in writing from the physician.***

1. Medication _____ Dosage _____ Route _____ Time given at school _____

Administration Instructions/ Special Directions _____

Prescriber Name _____ Prescriber Phone Number _____ Prescriber Fax Number _____

2. Medication _____ Dosage _____ Route _____ Time given at school _____

Administration Instructions/ Special Directions _____

Prescriber Name _____ Prescriber Phone Number _____ Prescriber Fax Number _____

3. Medication _____ Dosage _____ Route _____ Time given at school _____

Administration Instructions/ Special Directions _____

Prescriber Name _____ Prescriber Phone Number _____ Prescriber Fax Number _____

I request the above student be given the medication(s) listed above at school and school activities by qualified staff, according to the prescription or nonprescription instructions and a record be maintained. To the best of my knowledge, the student has not experienced any previous side effects from the listed medication(s).

I understand the law provides that there shall be no liability for civil damages as a result of the administration of medication where the person administering the medication acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I agree to provide safe delivery of medication and equipment to and from school and to pick up remaining medication and equipment or it will be properly destroyed.

I agree that qualified school personnel may contact the prescriber as needed by phone, mail or fax to clarify medication administration instructions and/or to exchange with the provider efficacy concerns relating to expected therapeutic results of above listed medication(s). I further agree that medication information may be exchanged with qualified school personnel who need to know in accordance with the Family Education Rights and Privacy Act (FERPA).

Parent/Guardian Signature _____

Date _____