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 _____