Authorization/Parental Consent for School to Provide Medication or Student Self-Administered Medication

Student Name: _____ _____ _____
Last First MI

Gender: **M** *or* **F** Date of Birth: _____ Grade: _____
MM/DD/YYYY

Contact Information:

Parent/Guardian Name: _____

Phone Number: _____ _____
Cell Day Phone

Emergency Contact _____ _____
Name Phone Number

Relationship to Student: _____

Primary Healthcare Provider: _____

Student Health Information:

Any known allergies? If yes, please explain: **Yes** *or* **No** _____

_____

_____

The student has been educated about his/her allergy and the signs and symptoms of an allergic reaction and how to prevent them: **Yes** *or* **No**

Will the student be taking more than one medication at school or while under the school's supervision: **Yes** *or* **No**

***** *If yes, you must provide a certification from your healthcare provider stating that the medications are not known to adversely interact or information on how to avoid any known adverse interactions.*

Student Consent for Students Grades 5th-12th:

I acknowledge that I have read, understand, and agree to comply with the school district's medication program policy. I also acknowledge and agree to comply with the district's drug and alcohol free policy, which contains restrictions related to medication, including rules prohibiting me from giving my medication to other students. Anytime I believe that I am having a reaction to my medication, I will report this information to my teacher or school employee. If I have received permission to carry medication (only inhalers and Epi-pens on a case-by-case basis are allowed to be carried by a student), I agree that I will not leave the medication unattended or accessible to other students.

_____ _____
Student's Signature Date

Medication Authorization:

Medication Name: _____

Relevant diagnosis: _____

Dates medication is to be provided:
Short term: ____/____/____ to ____/____/____

OR

Everyday until: **medication is gone** *or* **end of the school year**

Dosage (*amount*): _____

Time of Day: _____

Route *(circle one):* **mouth** **eye** **ear** **nose** **topical**

Form (*circle one*): **pill** **drops** **spray** **salve** **liquid**

Please list any serious reactions/adverse side effects that may occur from this medication:

_____

_____

Action/Treatment for Reactions: _____

_____

_____

Special Storage Instructions: _____

_____

Is any equipment required in order for the student to receive medication? If yes, please explain. **Yes** *or* **No** _____

_____

Please note that medications that are out of date or for which this authorization has expired must be picked up by the parent/legal guardian. Under no circumstances will the medication be released to students except medication that a student has been authorized to carry. When medications are not picked up by the parent/legal guardian, the medication must be destroyed.

Student Self-Administration:

This student has received instruction in self-administering this medication in a secure manner. In addition, the student has received education on any side effects or adverse interactions associated with the medication and how to prevent them.
(circle one) **Yes** *or* **No**

The student is capable of self-administering this medication in a secure manner.
(circle one) **No** **Yes-Supervised** **Yes-Unsupervised**

Confidentiality Waiver:

I (*parent/guardian's name*) _____ authorize (*health care provider*)_____ to provide health information from (*student's name*) _____medical records to Lisbon Public School. This disclosure of health information is required for the school to provide medication and/or oversee my child's self-administration of medication. This authorization shall become effective immediately and shall remain in effect for the duration of the medication administration. I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me, and delivered to the healthcare agencies and school listed above. My revocation will be effective upon receipt but will not be effective to the extent that the school or others have acted in reliance of this authorization.

I understand that the school will protect this information as prescribed by FERPA and that the information becomes part of the student's educational record. I have a right to receive a copy of this authorization. Signing this authorization is required in order for my child to obtain medication services in the educational setting.

_____ _____

Parent/Guardian Signature Date

Parental Consent:

I am the parent/guardian of _____. I give my permission for my student to take the aforementioned medication while in Lisbon Public School. I authorize the following individuals that have been certified in medication administration to provide medication to my child (*circle all that apply*):

Amanda Gerding **Sara Adair** **Holly Froehlich**

I acknowledge that I have read, understand, and agree to comply with the school district's medication program policy. I certify that the information included on this form is accurate to the best of my knowledge. I hereby release Lisbon Public School District and its employees from any claims or liability 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.

_____ _____

Parent/Guardian Signature Date