HIGHLANDS SCHOOL DISTRICT

MEDICATION ADMINISTRATION CONSENT & LICENSED PRESCRIBER ORDER

Student Name _____ **Date:** _____

School: _____ **Teacher/Grade:** _____

In accordance with school policy, medication(s) should be given at home before and/or after school. However, when this is not possible, prior to receiving **any** type of medication(s) at school, **each student** must provide the school nurse with a *Medication Administration Consent* form signed by the student's parent/guardian **and** a *Medication Order* from a licensed prescriber. **All Medications, prescription and non-prescription, must be in an original prescription bottle/container or original manufacturer's container and must be delivered to the school nurse by the student's parent/guardian. Students are not permitted to carry/possess medication(s), at any time, while in school.**

Parent/Guardian Consent:

I give my permission for my child, _____ to receive the medication(s) ordered by a prescriber during the school (see below). I understand that the medications will be given only by school health personnel according to my child's licensed prescriber's directions. I do hereby release, discharge, and hold harmless the Highlands School District, its agents and employees from any and all liability and claim whatsoever for the administration of the above medica tion to my child/ward should he/she develop an allergic or other reaction from the medication.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Name Printed: _____ **Phone:** _____

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LICENSED PRESCRIBER MEDICATION ORDER:

Patient's Name: _____ **Date:** _____

Name of Medication(s) _____

Route and Dosage: _____ **Route and Dosage:** _____

Time to Administer: _____ **Time to Administer:** _____

Discontinue Date: _____ **Discontinue Date:** _____

Allergies: _____

Possible Side Effects: _____

Licensed Prescriber Signature: _____

Licensed Prescriber Name Printed: _____