Education at its best.

MONTELLO SCHOOL DISTRICT

District Phone: 608-297-7617 Fax: 608-297-7726

Medication Administration Consent Form

Student Name: _____ Date of Birth: _____

Allergies: _____ Parent/Guardian Phone Number:_____

All medication MUST be in its original over-the-counter or prescription container with a valid expiration date.

- **Prescription medications: Form must be signed by both parent/guardian and physician/practitioner.**
- **Non-prescription medications: Form to be signed by parents/guardian.**
- **Each student and medication will require a separate form filled out.**

Medication Name:_____

Form of Medication: ☐ Tablet ☐ Capsule ☐ Liquid ☐ Cream ☐ Drops ☐ Nasal Inhalant ☐ Metered Dose Inhaler ☐ Lotion ☐ Ointment ☐ Patch ☐ Powder ☐ Solution ☐ Syrup ☐ Suppository

Medication Strength: _____ **Amount per dose to be given:**_____

Route: ☐ Oral ☐ Nasal ☐ Rectal ☐ Intramuscular ☐ Subcutaneous ☐ Feeding Tube ☐ Other:_____

Frequency: _____ **Time to be given**: ☐ Scheduled at:_____ ☐ Upon Student Request

Reason for Taking Medication:_____

Possible Side Effects/Considerations:_____

*****This portion ONLY applies to Asthma Inhalers, EpiPens, Glucagon, Insulin, or Birth Control for Overnight field trips: Student has been instructed on self-administration of medication and student may carry medication and self-administer.** ☐ Yes ☐ No

PRACTITIONER'S INFORMATION (needed for all prescription medications): Physician/Practitioner Name and Facility: _____

Signature:_____Phone:_____

Address:_____

(see next page)

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Parent/Guardian Consent: (Complete for all prescription & non-prescription medication at school)**.**

- **I will supply medication in its original, updated, properly labeled container.**
- I request & authorize that this medication be administered by school personnel as instructed or approved self-administration and carry.
- I agree to notify the School Nurse of any changes in my child's medication prescription.
- I authorize school personnel to exchange information verbally or in writing with school personnel and /or my child's practitioner regarding this medication or the conditions for which it is prescribed.
- I agree to hold the Montello School District, its employees & agents who are acting within the scope of the duties harmless in any & all claims arising from the administration of this medication.
- Empty medication bottles will be discarded unless personally requested.
- I am aware that medication is to be brought in directly by the parent/guardian and students are not allowed to have medication of any kind in their possession while at school.
- My signature indicates that I have fully read and understand the above information.
- In the event that your child will have some unused doses of medication left at the end of the school year**, please advise the school** on how you would like the medication returned by completing the following:

☐ I will arrange to pick up the unused portion of my child's medication.

☐ Please discard any unused medication (this is not an option for prescription medication).

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

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