NEPN Code: IAF-E (1)

ADMINISTRATION OF MEDICATIONS TO STUDENTS CONSENT FORM

1. I am the parent/guardian of _____ and I authorize my child/ward, date of birth _____ grade _____, to be administered the prescription/ nonprescription medication identified below while on school property or at a school-related event or activity by an employee trained in the administration of medication.

2. I hereby release the District and its employees and agents from liability for injury arising from the school's administration of the medication while on school property or at a school-related event.

3. I understand that the District and its employees are not responsible for medication administration after school hours and/or off school grounds (ex. Bus, away games).

4. I understand that if the student identified herein uses the medication in a manner other than prescribed, the student may be subject to disciplinary action by the school; however, any disciplinary action may not limit or restrict the student's immediate access to the medication.

5. I authorize the school to inform appropriate school employees who would have a need to know of the administration of medication (i.e., such as school nurse, instructors, teacher aides, school administrators, activity supervisors, bus drivers).

6. I acknowledge and agree that the school shall secure (store) the medication for the student until administration of the medication is necessary, and that the medication shall not be stored in the student's locker, with the exception of live saving asthma or anaphylaxis medications.

YES ○ / NO ◉ (mark one) Timber Lake School District 20-3 can supply my child Tylenol, Ibuprofen, antacids, and antihistamine. I understand, the school WILL still call informing me if these medications are given to my child.

YES ○ / NO ◉ (mark one) Timber Lake School District 20-3 can supply my child cough drops, antibiotic ointment, and anti-itch cream. I understand, the school WILL NOT call informing me if these medications are given to my child.

YES ○ / NO ◉ (mark one) Timber Lake School District 20-3 can supply my child with head lice treatment if necessary.

_____ _____

Signature of Parent/Guardian Date

Please list other medications (supplied by parent/guardian) on the back of this form.

Medication:_____

Dose: _____

Route (ex. Oral, inhaled, injected):_____

Time (if not given on a scheduled basis, write “as needed”:
_____

Authorization Start Date: _____

Authorization End Date: _____

Medication:
_____

Dose:
_____
_

Route (ex. Oral, inhaled, injected):_____

Time (if not given on a scheduled basis, write “as needed”:
_____

Authorization Start Date: _____

Authorization End Date:_____

Medication:
_____

Dose:
_____

Route (ex. Oral, inhaled, injected):_____

Time (if not given on a scheduled basis, write “as needed”:
_____
_____

Authorization Start Date: _____

Authorization End Date: _____

Adopted: 2-15-17
Revised: 6/13/18

NEPN Code: IAF-E (2)

Asthma and Anaphylaxis Medication Permission Form for Student Self-Administration

Student Information *(to be completed by the parent/guardian)*:

Student's Name:_____

Date of Birth _____ Grade: _____

School_____

Parent/Guardian's Name:
_____
_____

I am the legal guardian of the above student and authorize my child to self-carry and/or administer his/her prescription medication for asthma and/or anaphylaxis while on school property or at a school-related event or activity.

I release the school district and its employees and agents from liability for an injury arising from the student's self-administration of prescription medication while on school property or at a school-related event or activity unless in cases of wanton or willful misconduct.

Parent/Guardian's Signature _____
Date _____

Medical Information (to be completed by the medical provider):

Medication	Dose	When to use	Purpose

I am the medical provider for the above student and feel that he/she is capable of self-carrying and self-administering the above prescription medication and the student knows when and how to use the medication(s). I confirm that he/she has been diagnosed with
_____*Asthma and/or*
_____*Anaphylaxis.*

Medical Provider's Signature_____
Date _____

Date Authorization is Valid _____ to
_____

Adopted: 2-15-17
Revised: 6/13/18