FOX POINT • BAYSIDE
SCHOOL DISTRICT
A Valuable Education. An Education with Values.

PRESCRIPTION MEDICATION
Consent Form for School Hours

Student Name: _____ DOB: _____ Grade: _____

Teacher/Classroom: _____ School: _____

TO BE COMPLETED BY PHYSICIAN ONLY:

Name of Medication: _____

Reason for Medication: _____

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other (list below)

_____

Instructions - (Schedule and dosage to be given during school hours):

_____

_____

Start: _____/_____/20____ Stop: _____/_____/20____ OR ☐ End of School Year

For episodic/emergency use only:

Restrictions and/or important side effect(s): ☐ None anticipated ☐ Yes (please describe below)

_____

Instructions for specific conditions and/or circumstances in which contact should be made directly with the doctor or EMS personnel concerning conditions and/or reactions of the child to the prescribed medication: _____

_____

Special storage requirements: ☐ None ☐ Refrigerate

This student is both capable and responsible for self-administering this medication ***(Inhalers only)***:

☐ No ☐ Yes with supervision

Please indicate if you have provided additional information: ☐ As an attachment

Signature of Physician:_____ Date: _____

Physician Name: _____

Address: _____

Office Phone: _____ Fax: _____

To be completed by Parent/Guardian:

I give my permission for (name of child) _____ to receive the above medication at school according to standard policy.

Signature: _____ Date: _____

I hereby indemnify the School District or any of its personnel, employees or agents of any claim, demand, cause of action or liability asserted against them arising out of the child's taking, or failing to take, the medication in the dosage or at the time prescribed by the physician. I understand that the permission granted will be terminated in accordance with the physician's directive, or otherwise automatically at the close of this current school year.