SCHOOL DISTRICT OF BELLEVILLE

CONSENT AND INSTRUCTIONS FOR ADMINISTERING MEDICATION AT SCHOOL

Student's Name _____ Grade _____

Address _____ Phone_____

Reason for Medication (diagnosis)_____

Medication	Dose	Route	Time	Special Instructions/Precautions	Stud. Admin.
					☐
					☐
					☐
					☐

I hereby give my consent to the person or persons designated below to administer the above referenced medication to my child according to the written instructions contained herein and, in the case of prescription medication, to contact the child's physician.

I further agree to hold the School District of Belleville, its officers, employees, and agents, who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school to my child.

I further agree to notify the school nurse when any change in the above orders is necessary.

- ❑ I give permission for student to carry and self-administer medication checked above. If student is younger than 18, the parent/guardian assumes all liability related to the student's use, timing and technique in self administering this medication.

Date _____ _____

Parent's or Guardian's Signature

If a prescription medication is involved, contact should be made with me should the student receiving the medication develop any of the following conditions or reactions to the medication (if none, so state).

_____

Date _____ _____

Physician's Signature (**If prescription medication**)

The undersigned hereby designates the following individual(s) who are authorized to administer the medication to the student referenced above pursuant to the written directions contained herein

_____

_____

Date _____ _____

School Principal's Signature

Note: A record will be kept on the when medication is administered.

Student Name ____

Medication ____

DATE/TIME	OBSERVATION	AMOUNT	SIGNATURE