LAONA SCHOOL DISTRICT
PARENT/GUARDIAN MEDICATION CONSENT FORM

Full Name of Child to be Given Medication _____

Name of Drug and Dosage _____

When Medication is to be Given _____ Number of Days _____

Name and Phone Number of Physician Prescribing Medication _____

Reason for Medication _____

Name of Person(s) who will be giving medication during school hours _____

I hereby give permission to the above named persons to give the medication(s) to my child according to the directions stated above and further authorize them to contact the child's physician. I agree to hold the Laona School District, its 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.

I agree to notify the school in writing at the termination of this request or when any change in the above order is necessary.

_____ Date _____
(Signature of Parent/Legal Guardian)

_____
(Address)

This form must also be completed for the administration of non-prescription (over-the-counter) medications.

APPROVED BY: District Administrator _____

NOTE: Before a medication will be administered by the school or an agent thereof, a PHYSICIAN ORDER FOR MEDICATION ADMINISTRATION form shall be completed and returned to the school principal.

PHYSICIAN ORDER FOR MEDICATION ADMINISTRATION

TO WHOM IT MAY CONCERN:

_____ was seen in our clinic recently.

_____ was prescribed for him/her and it will be necessary for him/her to take it during school hours.

_____ Date _____
(Signature of Physician)

_____ _____
(Name of Clinic) (Address)