Winterset Community Schools

CONSENT TO RECEIVE PRESCRIPTION & OVER-THE-COUNTER MEDICATIONS

STUDENT _____ GRADE_____

PRESCRIBER_____ PHONE_____

NAME OF PHARMACY_____

NAME OF MEDICATION_____

DIAGNOSIS_____

PLEASE GIVE THE ABOVE MEDICATION:

DOSAGE_____ TIME OF DAY_____

STARTING DATE_____ ENDING DATE_____

AMOUNT SENT_____

I request that the prescribed drugs or medication be dispensed according to these written directions. I request that a qualified staff person give this medication. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for damages as a result of the administration of medication where the person administering the medication acts as an ordinary reasonably prudent person would under the same circumstances and that the school district and the school nurse are to incur no liability, except for gross negligence, as a result of injury arising from the administration of medication.

PARENT/GUARDIAN_____

SIGNATURE_____ DATE_____

HOME PHONE _____WORK PHONE_____

MEDICATION WILL NOT BE GIVEN IF IT HAS EXPIRED OR IT HAS AN IMPROPER LABEL. PLEASE CHECK THE CONTAINER BEFORE SENDING IT TO SCHOOL.

SUGGESTION: WHEN PICKING UP YOUR CHILD'S PRECSRIPTION ASK YOUR PHARMACIST FOR A BOTTLE LABELED FOR SCHOOL USE.

PERMISION FOR DISPOSAL OF MEDICATION

_____ I will pick up my student's medication within 1 week of last day of school.

_____ Discard any remaining medication.

If any medication is left after the last day of school, it will be discarded 1 week after school is out for the summer.

SCHOOL IS NOT RESPONSIBLE FOR MEDICATIONS NOT STORED IN THE NURSE'S OFFICE.