FORM # 5 Please complete for medication in school.

Appendix A

Osseo Area Schools - Independent School District 279

Medication Administration Consent Form

Name of Student _____ Birthdate _____ ID# _____

School _____ School Year _____ Grade _____

Medical Condition	Medication	Dosage	Time	Route	Possible Side Effects
1.					
2.					
3.					

Other Considerations/Directions _____

Start Date _____ Stop Date _____

_____ _____

(Print) Name of Physician/Licensed Prescriber — Signature of Physician/Licensed Prescriber

_____ _____ _____

Clinic Address — Phone Number — Date

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Parent/Guardian Authorization

1. I request that the above medication(s) be given during school hours as ordered by this student's physician/licensed prescriber. I also request the medication(s) to be given on field trips, as prescribed.
2. I release school personnel from liability in the event of adverse reactions resulting from taking the medication(s).
3. I will notify the school of any change in the medication(s), (example: dosage change, medication is discontinued, etc.)
4. I give permission for the health specialist to communicate with the student's teachers about the student's health condition and the action of the medication(s).
5. I give permission for the health specialist to consult with the above named student's physician/licensed prescriber regarding any questions that arise with regard to the listed medication(s) or medical condition being treated by the medication(s).
6. I give permission for the medication(s) to be given by designated personnel as delegated by the health specialist.

☐ If there is remaining medication, I give permission for the school to send this home with my child.

_____ _____ _____

Date — Parent/Guardian Signature — Relationship to Student

Note: Medication is to be supplied in the original/prescription bottle.

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