

Boone County Schools
 School Health Services Department
Medication Administration Consent Form
 In-school/ After-school hours/ Field trip (including self-administration)

Prescribed medications (including herbal and dietary supplements) and over the counter medications shall be given according to the instructions below. All prescription medication MUST be in the original pharmacy container, labeled with student name, prescribing healthcare provider, strength and dose of medication and directions for use, including a time(s) for dosing. Over the counter medications MUST be in their original containers. No more than one week's supply of prescription medication may be received at school; for a field trip, only the amount of medication required for the event will be accepted. Please refer to Boone County Schools medication policy and procedures for more detailed information. This consent is only valid for the current school year.

Student's Name: _____ **Date of Birth:** _____ **Grade:** _____

Allergies: _____

****Please advise the school nurse immediately of any changes in medication or dosing.****

Medication 1: _____ Diagnosis/ Condition: _____					
Dose (mg/ml): _____ Route: _____ Administration time(s): _____					
Possible side effects: _____					
** In the case of emergency medication (inhaler, epinephrine, glucagon, or FDA approved seizure medication) this student has received training, and is capable of the following:					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">Physician's initial in appropriate box(s)</td> </tr> </table>	Physician's initial in appropriate box(s)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">_____ may CARRY medication</td> </tr> </table>	_____ may CARRY medication	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">_____ may SELF-ADMINISTER medication</td> </tr> </table>	_____ may SELF-ADMINISTER medication
Physician's initial in appropriate box(s)					
_____ may CARRY medication					
_____ may SELF-ADMINISTER medication					

Medication 2: _____ Diagnosis/ Condition: _____					
Dose (mg/ml): _____ Route: _____ Administration time(s): _____					
Possible side effects: _____					
** In the case of emergency medication (inhaler, epinephrine, glucagon, or FDA approved seizure medication) this student has received training, and is capable of the following:					
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_____ may CARRY medication					
_____ may SELF-ADMINISTER medication					

Specific to field trips: In the case of field trips or school-related functions, slight adaptations to medication administration times may be necessary. Unless otherwise indicated, student may self-administer medication with school-trained personnel while on an in-state or out-of-state field trip.

I request trained Boone County School employees to administer or supervise the administration of this medication in accordance with Boone County Schools' Medication Administration Guidelines and the above instructions. I release Boone County School District and any of its employees (hereinafter the "District") from any liability or harm which is suffered by the student (named above) as a result of this request. I further agree to indemnify and hold the District harmless from any legal action or other attempts to acquire compensation, including damages and legal and medical fees, from the District whenever the District has acted in accordance with the information provided by my child's physician.

Trained Unlicensed School Personnel: The Boone County Board of Education has adopted a procedure in which a staff member, from the school the child is attending, will administer either an injection, prescribed medication or other emergency procedure in the event of a crisis. The undersigned understands that the staff member administering the above care may not be a licensed healthcare professional, but that this staff member will undertake to do his or her best to comply with the procedure as developed by the student's physician in the case of a life threatening emergency wherein immediate intervention is required.

Parent/ Guardian signature: _____ **Date:** _____

Physician signature: _____ **Date:** _____

Physician name: _____ **Phone number:** _____

****Staff administering medication are trained annually by a registered nurse.****