Richfield School District Jnt. #1

Medical Consent Form

****All must be in its original container with label intact****

Student's Name_____ Date_____

Home Phone_____ Parent Daytime Phone_____

Section I: For NON-PRESCRIPTION Medication

1. Name of medication_____ Amount/Dose_____

   Times to be given_____ Duration_____

   Reason for Medication_____

2. Name of Medication_____ Amount?Dose_____

   Times to be given_____ Duration_____

   Reason for Medication_____

Section II: For Prescription Medications

*This portion must be completed by a physician, physician's assistant or nurse practitioner prior to the student taking medication at school. Medications will be stored and dispensed in the school's Main Office. The exception to this is epi-pens and inhalers, which may be carried by the student with physician and nurse written approval.

Medication	Route				Conditions Under Which to Medicate	Contact Physician When:
1)						
2)						
3)						

*Students with asthma inhalers or epi-pens for allergic reactions:

____This student may carry and self-administer medication.

____This student needs supervision and/or assist with administration.

I agree to retain power to direct, supervise, decide, inspect and oversee the administration of such medication(s). Direct contact shall be made with me at any time should you have questions.

Hosptial/Clinic/Office:_____ Address:_____

Physician's Signature:_____ Phone#:_____ Date:__/__/__

Section III: Parental Permission

I hereby give permission to the people named below to give the medication(s) to my child/ward according to the directio stated above and further authorize them to contact the child's physician. I agree that the school District, its employees and agents who act within the consent granted by this document, shall not be liable for any claims that I may have arising from the administration of this medication to my child/ward at school.

Signature of Parent/Guardian:_____ date__/__/__

Address:_____ Phone#:_____

Administrative Authorization:

The following staff is authorized to dispense medication: designated office staff

Principal's Signature:_____ date__/__/__