

**EASTERN SCHOOL DISTRICT
FORM A –
PARENT/GUARDIAN MEDICATION CONSENT AND RELEASE FORM**

(To be completed by Parent/Guardian)

Student Name: _____ D.O.B: _____

Address: _____

Emergency Contact(s): _____ Tel #: _____

School: _____ School Year: _____

Grade/Level: _____ Room/Class: _____ Teacher: _____

Prescribed Medication:

I hereby request, authorize and empower the Eastern School District to administer medication as described herein or treatment as described in Form B (see attached) to the student named above. I release the Eastern School District and any staff member of the student's school from any legal liability that may result from the administration of such medication or the giving of such treatment. I also agree to indemnify the Eastern School District against claims at any time made by the student named or by any other party arising out of the administration of medication or treatment described herein to my child.

I further acknowledge awareness that school staff members are not medically trained personnel and that my expectations of school personnel in the knowledge and administration of medication to my child or any other child shall be no greater than that of their professional field.

PARENT/GUARDIAN PERMISSION:

I request and give consent to allow a staff member to administer this prescribed medication at school with the in full realization that that person is not a medically trained person.

Signature of Parent/Guardian

Date

Signature of Parent/Guardian

Signature of Witness

**EASTERN SCHOOL DISTRICT
FORM A-PARENT/GUARDIAN MEDICATION CONSENT AND
RELEASE FORM
(CONTINUED)**

FOR SCHOOL USE ONLY

Form B Submitted and Completed: _____ **Yes** _____ **No**

SCHOOL AUTHORIZATION TO ADMINISTER MEDICATION

Your request is hereby granted and medication will be administered to
_____ in accordance with the directions of the attending physician
as indicated in Form B (Medication Administration-Physician's Report).

Signature of Principal

Date

Signature of Witness

Date

**NOTE: The original copy of Forms A and B are to be maintained together
in the student's Confidential File.**

Page 2 of 2

**EASTERN SCHOOL DISTRICT
FORM B - PHYSICIAN'S REPORT**

Student Name: _____ D.O.B.: _____

Address : _____ MCP# _____

Parent/Guardian(s): _____

Medical condition requiring treatment during school hours: _____

TYPE OF IN-SCHOOL INTERVENTION NECESSARY;

1. Medication(s):

| Medication Prescribed | Dose | Frequency | Required Time of Administration | Method of Administration | Purpose of Medication |
|-----------------------|------|-----------|---------------------------------|--------------------------|-----------------------|
| | | | | | |

2. Other (be specific):

3. CONSIDERATIONS

a. Possible side effects of medication(s)/treatment and remedial action for side effects

**EASTERN SCHOOL DISTRICT
FORM B - PHYSICIAN'S REPORT
(CONTINUED)**

b. Type of storage and safe keeping required for medication _____

c. Will it be detrimental to the student's health if a single dose/treatment is omitted?
Yes ____ No ____

d. Please check the appropriate box to complete this statement:

Persons administering the medication/treatment as described above

____ **do need** to have had medical training or certification by the Community
Health Nursing Division

____ **do not need** to have had medical training or certification by Community
Health Nursing Division

3. The student named above must have this medication/procedure
administered/performed during school hours in order to be able to attend school

Yes ____ No ____

4. Is this student able to administer his/her own medication? Yes ____ No ____
If yes, give details:

Signature of attending physician

Name of attending physician and telephone numbers

**EASTERN SCHOOL DISTRICT
FORM B - PHYSICIAN'S REPORT
(CONTINUED)**

| FOR SCHOOL USE ONLY |
|---|
| Forms A and B have been received and the requests are hereby granted Yes ____ No ____ and medication will be administered to _____ in accordance with the information provided. |
| Principal's Name: _____ |
| Principal's Signature: _____ |
| Witness's Name: _____ |
| Witness's Signature: _____ |
| Date: _____ |

NOTE: The original copy of Forms A and B are to be maintained together in the student's Confidential File.