SCHOOL DISTRICT OF HILBERT

Medication Consent Form

Student_____Grade_____ Date_____

Date of Birth_____ School_____ Teacher_____

All medications administered by HSD staff are only available to students during school hours (7:00 a.m.- 4:00 pm), must not be expired, and in a properly labeled pharmacy box/bottle. Ask your pharmacy for any needed labels or containers.

Section 1: Prescription Medications (Provider Signature Required On Page 2)

Medication Name/Strength	Dose	Route*	Time	Reason/Diagnosis	Expiration Date

**Route = oral, inhaled, topical, injectable, etc.*

Section 2: Over-The-Counter (OTC) Medications

Medication Name/Strength	Dose	Route*	Time	Reason/Diagnosis	Expiration Date

**Route = oral, inhaled, topical, injectable, etc.*

As the parent or guardian of the above-mentioned student, I will keep the school district aware of any changes in medication(s) or health concerns for my child.

I hereby give permission to designated school personnel to give medication to my child during the school day, including when away from school property on official school business, according to the written instructions of the doctor as shown on this form.

I hereby give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication.

I further agree to hold the School District of Hilbert, and the HSD employee(s) who is (are) administering the medication harmless in any or all claims arising from the administration of this medication at school.

_____

Signature of Parent/Guardian Date

SCHOOL DISTRICT OF HILBERT

The Physician Information/Consent section must be completed whenever the following conditions exist:

- An OTC medication is to be given daily for greater than 10 days in a row;
- An OTC medication is to be given in a dosage other than the recommended therapeutic dose; or
- Any prescription medication

Any medication/substance that is not FDA-approved may not be given by HSD staff.
Expired medications may not be given by HSD staff.

Provider Information/Consent

Print Name of Provider_____Clinic Name _____

Phone Number_____ Fax Number _____

Address _____

Signature of Provider_____Date_____

I agree to allow my student to transport the medication package (filled or empty) to and from school for the purpose of maintaining medication needed at school for administration and bringing home medication at the end of the school year.

☐
Yes

☐
No

**Note to Health Care Provider-This document serves as medication and treatment orders.*