

TEMPE UNION HIGH SCHOOL DISTRICT
Consent for Giving Prescription and Non-Prescription Medications at School
School Year _____ to _____

Student Name _____

School _____ Student ID _____

Medication must be delivered to school in the original container with the label intact.

The medication is to be given in the following manner:

Name of Medication: _____

Strength of Medication: _____

Amount to be Given: _____

Time of Administration at School: _____

Route of Administration (by mouth, etc.): _____

Comments and/or Instructions: _____

Reason for Medication: _____

Date Medication is to be discontinued: _____

Student may self-carry and self-administer their medication (**Valid only for diabetes, asthma, and anaphylactic reactions. Students may not carry any other medications.**)

Healthcare Provider Name: _____ Phone No. _____
(Please print)

Healthcare Provider Signature

Date

I hereby request and my consent for the School Nurse or person designated by the School Administration to give my child medication prescribed by the below listed licensed health care provider. **I acknowledge that it may be necessary for the assistance in administration of medication to my child to be performed by an individual other than a nurse, and specifically consent to such practice.**

I understand the law provides that there shall be no liability for civil damages as a result of the assistance in administration of such medication and/or treatment where the person assisting in the administration of such medication and/or treatment acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I understand my child's medication is to be presented to a school representative by an adult. I will assume full responsibility for the supply, appropriate transportation and maintenance of above medication. If any changes in medication or dosage occur, the school must be notified immediately, and a new form must be completed. I give permission for the exchange of information directly with the healthcare provider regarding my child's medication. **Any medications not picked up by the last day of school by the student's parent/guardian, or other designated adult, will be destroyed.**

Parent/Guardian Home Phone #

Parent/Guardian Work Phone #

Parent/Guardian Signature

Date