Unified School District 322
Onaga-Havensville-Wheaton

Permission for Medication Administration by ***Staff***

Name of Student: _____ DOB: _____
Emergency Contact: _____ Phone _____ Relationship _____
Ordering Provider _____ Provider's Phone _____
Medication: _____ Dosage: _____
Medication start date: _____ Medication end date: _____
Time medication is to be administered at school: _____
Reason for Medication (Diagnosis): _____
Additional comments: _____
_____
_____

I hereby give my permission for school nurse or (if nurse is unavailable) a delegated trained staff member, to administer the above medication at school as ordered above. I understand that it is the parent's/guardian's responsibility to furnish the medication in original bottle/packaging with label, and notify school nurse with any changes in medication. I acknowledge that the school incurs no liability for any injury resulting from the administration of this medication and agree to indemnify and hold the school, school nurse, or any delegated staff, harmless against any claims relating to the administration of this medication. The medicine will be kept secured in the School Nurse's office with the current pharmacy label or original packaging for over the counter medications, and this permission form in the same area.

Delegated Trained Staff Members:

Staff Member	Training Completion Date / RN Validation
_____	_____
_____	_____
_____	_____
_____	_____

_____
Signature of Parent/Guardian Date

_____
Signature of Health Care Provider Date

_____
School Nurse Reviewed - Date