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: ____
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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. I understand that it is the parent's/guardian's responsibility to furnish the medication in original bottle 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 OHS 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
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

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Signature of Parent/Guardian Date

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Signature of Health Care Provider Date

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School Nurse Reviewed - Date