Consent for Prescription Medication Administration
Beresford School District #61-2

1. I, ______________________________, am the parent or guardian of ______________________________, and I authorize my child/ward to be administered the prescription medication identified below while on school property or at a school-related event or activity by the school nurse or employee trained in the administration of prescription medication.

2. I hereby release the District and its employees and agents from liability for injury arising from the school's administration of the medication while on school property or at a school-related event.

3. I understand that if the student identified herein uses the medication in a manner other than prescribed, the student may be subject to disciplinary action by the school. However, any disciplinary action may not limit or restrict the student's immediate access to the medication.

4. I authorize the school to inform appropriate school employees who would have a need to know of the administration of medication (i.e., school nurse, instructors, teacher aides, school administrators, activity supervisors, bus drivers).

5. I acknowledge and agree that the school shall secure (store) the medication for the student until the administration of the medication is necessary, and that in no circumstances shall the medication be stored in the student's locker.

6. I acknowledge that the medication must be brought to school by an adult in the original bottle or package.

______________________________________ ________________________

Signature of Parent/Guardian Date

To be completed by medical professional:

Medication: ____

Dose: ____

Time: ____

Authorization Start Date: ______________________________

Authorization End Date: ______________________________

______________________________________ ________________________

Signature of Medical Professional Date

Phone # ________________________