HILLSBORO SCHOOL DISTRICT MEDICATION FORM

Please make every effort to give your child his/her scheduled medications at home and avoid having to have them be given during school hours. Medications are to be administered at home whenever possible. If it is necessary for a student to receive medications at school, all appropriate portions of this form must be completed before medication can be given at school.
One form is required for **EACH** medication.

Student Name	Date of Birth	Grade
Medication/Procedure	Reason	Dosage/Frequency/Time
School Year	Student's Practitioner/Clinic	

NOTE: For prescription medication: Signed Parent Consent **AND** signed Physician's Order required.
For non-prescription medication: Signed Parent Consent required.

PARENT/GUARDIAN CONSENT: (Complete for all Medication/Procedures at school)

- I request and authorize that this medication be administered at school by school personnel.
- I will supply medication in its original, updated, properly labeled container.
  (For prescriptions- request an extra bottle from pharmacy.)
- I further understand that all medication should be delivered to the school by parent/guardian/responsible adult. If medications are sent to school with my student, I accept responsibility/accountability for the risk of discrepancies during transport.
- This order is in effect for this school year unless otherwise indicated.
- I will obtain a new physician's order and notify the school in writing for any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
- I understand that medication may be given by non-medically trained school personnel.
- My signature indicates that I have fully read and understand the above information.
- ASTHMA INHALERS and EPI PENS ONLY: This student is capable of self-administration and may carry an inhaler or EPI pen and self-administer at school. YES____ NO_____

I release Hillsboro School District and employees from any liability claims as a result of the administration of this medication or procedure as directed above.

_____ _____ _____
Date **Parent/Guardian Signature** **Phone #**

PHYSICIAN'S ORDER: The above medication/procedure is to be administered/performed during the school day in accordance with the above instructions and agreements. I agree to accept communication about student/medication/procedure and understand medication may be given by non-medically trained school personnel.

Student & parent/guardian have been instructed and student may carry medication and self-administer in school:
YES_____ NO_____

Clinic_____ Phone #_____ Fax#_____

Physician Name_____

Physician Signature_____ Date_____