Hallsville Independent School District

Consent form for administration of medication by school personnel

The HISD school board policy regarding administering medication is as follows:

- This written request must identify the medication and clearly state the instructions for giving the medication.
- Prescription medication must be in its original container with a pharmacy label stating the student's name; name of medication; dosage to be administered, doctor's name, and date the prescription was filled.
- Non-prescription medication must be in its original container and appropriately labeled for the student's current age/weight.
- All medications must be provided by a parent or legal guardian and delivered directly to the campus nurse.
- All medication must be kept in the nurse's office and be administered by the nurse or another authorized district employee.
- Parents/guardians must check out medication(s) by the last day of school or it will be properly disposed of.

Name of student:_____

Student's date of birth:_____Current Grade:_____

Name of medication:_____

Dose (how many):_____When to give:_____

Prescribing physician (if applicable):_____

Medical diagnosis/purpose for this medication:_____

Additional instructions:_____

**For prescription medications only:*

Do we (HISD personnel) have authorization to administer this medication while off campus during school sponsored events?

- ☐ Yes, administer medication off-campus
- ☐ No

Do we (HISD personnel) have authorization to administer a missed dose of morning medication, if requested by parent/guardian?

- ☐ Yes, administer a missed dose upon request.
- ☐ No
- ☐ Not applicable

I give my permission for the above student to take the above prescribed/non-prescription medication while attending Hallsville schools. I hereby acknowledge that I have read and understand the school board policy relating to the taking of medications. I hereby release HISD and its employees from any claims of liabilities connected with its reliance on this permission and agree to indemnify, defend, and hold harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the above licensed prescriber.

_____

Signature of parent/guardian Date

_____

HISD staff signature Initial Count Date

THIS FORM IS VALID THROUGH THE LAST DAY OF THE CURRENT SCHOOL YEAR ONLY