Black Hawk School District

CONSENT for PRESCRIPTION MEDICAITON

Please complete *both* sections

STUDENT NAME: _____ BIRTHDATE: _____

GRADE: _____

*This form will need to be completed **annually** if your child receives daily medications at school.

FOR COMPLETION BY PHYSICIAN or HEALTH CARE PROVIDER

Medication **Dosage** **Frequency**

_____

_____

_____

Side Effects: _____

PHYSICIAN/PROVIDER SIGNATURE: _____ DATE: _____

Clinic Address: _____ Phone: _____

FOR COMPLETION BY PARENT/GUARDIAN

___ I give permission for the above medication(s) to be given as directed and/or communicate with the provider(s) if necessary.

I authorize trained staff to administer this medication(s) at school and if the need arises the school nurse can communicate with the physician/health care provider as necessary regarding this medication. I authorize health personnel under HIPPA and FERPA to communicate health information on a need to know basis. This allows for conversation with administration per school nurse and as necessary with teaching and support staff.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Home Phone: _____ Work Phone: _____

***Medication MUST be in the original prescription bottle.**
***The label must be current with student's name, medication, and date.**
***Dosage changes require written notice with provider/health care provider and parent/guardian signature.**