Medication Administration Consent Form

Dear Parent or Guardian,

Any medication, prescription or non-prescription, which a student requires during school hours, must be delivered by a parent/guardian and given to the school nurse or secretary. Any medication found in a student's possession, including his/her backpack or locker, could result in suspension or expulsion. All unauthorized medications will be confiscated.

Please keep in mind that school is not the best place to administer medication. Doses can be forgotten during the busy school day. If your child's medicine can be administered at home, please do so. Remember, the **initial dose of a medication cannot** be administered at school.

In order for the school to administer **any** medication to your student, you will need the following:

- *A **Walton-Verona Independent District Administration of Medication Permission Form** completed and signed by your child's physician and by the parent/guardian. This form is available in the school office or first aid room.*
  - *Notes from parents requesting medication to be administered to students will NOT be accepted.*
  - *We CANNOT accept telephone permission for medication administration from a physician. Your doctor's office may fax the signed form to the school at 859.485.1810.*

- *Medication must be in the original container. All prescription medications must have the student's name on the label with directions for administration that match the permission form.*

If the above procedures are not followed, we will not be permitted to administer medication to your student at school. Medications containing narcotics for pain relief or sedation should not be sent to school. For their own safety, children requiring this level of medication should remain at home until this medication is no longer required during the school day. Contact school nurse regarding this.

- All medications not picked up from school by a parent/guardian by the student's last day of school will be discarded. No medication will be sent home with students.

- All expired medications will be destroyed within 7 days of expiration date if not picked up by parent/ guardian. Please make note of the expiration date for your records prior to bringing medication to school.

We appreciate your cooperation in this matter and hope you understand these procedures are for the safety of all of our students.

revised 8/2021

Walton-Verona Independent School District
Medication Administration Consent Form

Dear Parent/Guardian,

If medication administration is required during the school day, whether prescription or non-prescription, this form must be completed and signed by both a physician and parent. For any questions, please contact the school nurse.

All medications are kept in the first aid room and must be in the original container with label affixed. For prescription medication, your student's name must be on the label and the label must match the directions on this form. The initial dose of a medication cannot be administered at school. Pursuant to *KRS 158.834 and KRS 158.836*, the Board of Education policy permits a responsible, trained student to carry and/or self administer emergency medication for asthma, severe allergic reaction, seizures, or diabetes on his/her person for immediate use in a life threatening situation with a written physician's order, parent request, school nurse and principal approvals. We accept the parent request and physician statement. We will permit and assist the student to be responsible, but reserve the right to withdraw the privilege if the student shows signs of irresponsible behavior or there is a safety risk. We will contact the parent as soon as possible in this event.

STUDENT: _____ DOB: _____ GRADE: _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

1. Medication: _____ Dosage: _____ Directions: _____
Administration Time: Lunch ____ or _____Route: _____ Diagnosis/Condition: _____
Possible Side Effects: _____ Duration: Start_____ Stop_____
****In the case of an emergency medication, student has received training and may ____CARRY and/or ____ SELF ADMINISTER this medication.**

PHYSICIAN'S INITIALS _____

2. Medication: _____ Dosage: _____Directions: _____
Administration Time: Lunch ____ or _____Route: _____ Diagnosis/Condition: _____
Possible Side Effects: _____ Duration: Start_____ Stop_____
****In the case of an emergency medication, student has received training and may ____CARRY and/or ____ SELF ADMINISTER this medication.**

PHYSICIAN'S INITIALS _____

I give permission for school personnel to communicate with the Physician in regards to these orders /medications.

******PARENT/GUARDIAN AUTHORIZATION FOR SELF CARRY/SELF ADMINISTER ONLY******

I request that my child, named above, be permitted to: _____ **carry** _____ **self-administer** the above **emergency medication**. I take responsibility for this permission. I understand the medication must be in the original pharmacy container, labeled with name of student, prescribing health care provider, and medication; date of original prescription; strength and dose of medication; and directions for use.

_____	_____	_____	_____
PARENT SIGNATURE	**DATE**	**STUDENT SIGNATURE**	**DATE**

During school hours, I understand teachers, assistants, nurses or other trained school personnel may be administering these medications according to the specified physician's order and district policy. Schools have established individual procedures for where and when the students receive their daily medications. The student has the ultimate responsibility of reporting daily for their medication.

No medications will be sent home with students. All unused medications not picked up from the school by a parent/guardian by the student's last day of school will be discarded.

I give permission for the storage and administration of this medication by trained school personnel accompanying my student on a field trip or school related function in Kentucky and/or other states. In the case of field trips or school related functions, slight adaptations to the time the medication is administered may also be necessary. Unless indicated otherwise, student may self administer medication with school trained personnel supervision while on a field trip. I hereby release the Walton-Verona Board of Education and its employees from any claims or liabilities connected with their reliance on this permission and agree to indemnify, defend and hold them harmless from any claim or liability connected with such reliance.

_____	_____	_____
***Parent/Guardian Signature**	**Parent Phone**	**Date**
_____	_____	_____
***Physician Signature**	**Physician Phone**	**Date**
_____	_____	_____
***Print Physician Name**	**Physician Address**	**Physician Fax**

revised 8/2021