Chandler Unified School District #80

Consent for Giving Prescription and Non-Prescription Medications for Extended Field Trips

Please check here if **NON**-prescription ☐

Student Name:_____DOB:_____

School:_____Grade:_____Date:_____

For prescription medication, the licensed healthcare provider must complete the information required below. Parent/Guardian may complete the information below for non-prescription medication. Medication must be delivered to school in the original container with the label intact. The medication is to be given in the following manner:

Name of Medication: _____

Strength of Medication: _____

Amount to be Given: _____

Time of Administration at School: _____

Route of Administration (by mouth, etc.):_____

Comments and/or Instructions: _____

Reason for Medication: _____

Date Medication is to be discontinued: _____

Any Known Allergies: _____

Medication amount dropped off/Date: _____ Medication amount picked up/Date: _____

Licensed Healthcare Provider Name: _____Phone No._____
(print)

_____
Licensed Healthcare Provider Signature Date

I authorize the School District and its employees and agents, on my behalf, to assist in the administration of the medication identified as ordered by my child's physician. **I acknowledge that it may be necessary for the assistance in administration of medication to my child to be performed by an individual other than a nurse, and specifically consent to such practice.**

I understand the law provides that there shall be no liability for civil damages as a result of the assistance in administration of such medication and/or treatment where the person assisting in the administration of such medication and/or treatment acts as an ordinarily reasonably prudent person would under the same or similar circumstances. I understand my child's medication is to be presented to a school representative by an adult. I will assume full responsibility for the supply, appropriate transportation and maintenance of above medication. If any changes in medication or dosage occur, the school must be notified immediately, and a new form must be completed. I give permission for the exchange of information directly with the healthcare provider regarding my child's medication.

_____
Parent/Guardian Signature Date

_____
Parent/Guardian Home Phone # Parent/Guardian Work Phone #

_____
RN Signature Date

For Office Use Only

Month	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Initials/Time							
Initials/Time							
Initials/Time							

Person Administering Medication/Treatment: _____
Name Initials