

West Bend Mallard Community School District (secondary)
Parental Permission for administering PRESCRIPTION medication at school

Student Name: _____
Medication: _____
Reason for medication: _____
Dosage: _____
Time to give medication: _____
Physician/Prescribers Name: _____ Phone Number: _____
Special Instructions: _____

I request that the prescribed medication be administered by a qualified staff person according to the written directions given. I agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personally who need to know. I understand the law provides that there shall be no liability for damages as a result of the administration of medication where the person administering the medication acts as an ordinary reasonably prudent person would under the same circumstances and that the school district and the school nurse are to incur no liability, except for gross negligence, as a result of injury arising from the administration of medication. I will comply with the procedure listed on the back of this form related to the administration of medication at school.

Parent/ Guardian name: _____
Signature of Parent/Guardian: _____
Date: _____ Home Phone: _____ Work Phone: _____

***MEDICATION WILL NOT BE GIVEN IF IT HAS EXPIRED OR IT HAS AN IMPROPER LABEL.
PLEASE CHECK THE CONTAINER BEFORE SENDING IT TO SCHOOL.***

Permission for disposal of unused medication at the end of the school year—Please check one.

- _____ I will pick up and unused medication at the end of the school year.
_____ Please send any unused medication home with my child. The school district will not be responsible for the medication once it is in the possession of my child.
_____ Please discard any unused medication.

Parent/Guardian Signature: _____

Permission for inhalers: Iowa law requires that students who carry inhalers throughout the school day must have written parent consent and written prescribers consent with the purpose of the medication, dosage, times or special circumstances under which the medication is to be given. **If your child is to carry his/her inhaler with them at all times, please have the prescriber fill out the information at the top of the page AND both sign below.**

I have instructed the above named student in the proper way to use his/her inhaler. It is my professional opinion that he/she should be allowed to carry and use that medication by himself/herself.

Physician/Prescriber Signature: _____ Date: _____

I request that the above named student carry and self-administer his/her inhaler during school and school activities according to the authorization and instructions given.

Parent/Guardian Signature: _____ Date: _____