

**West Bend-Mallard Community School District**  
**Parental Permission for Administering PRESCRIPTION Medication at School**

Student Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for Medication: \_\_\_\_\_

Time Medication is to be Given: \_\_\_\_\_

Physician/Prescriber's 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 personnel 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 reasonable prudent person would under the same circumstances and that the school district and the school nurse 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 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 IF 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 any 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:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Permission for Inhalers:** Iowa law requires that students who carry inhalers throughout the school day must have written parent consent and written prescriber's 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 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:** \_\_\_\_\_