USD 320 Consent and Medical Authorization

School: ____
Activity: ____
Date of Activity: ______________________________________

____ has my permission to attend the above listed activity/event on the scheduled date. I understand that the activity/event is a school sponsored event and may result in absence from regularly scheduled classroom time or activities. I understand that if my student must be sent home early for disciplinary reasons, it will be at my expense. The school district representative supervising the activity/event is hereby granted my permission to seek and authorize any medical treatment that may be necessary for their health and well-being in the event of accident or injury while he/she is attending the activity/event listed above for which my permission has been given.

Date: ____________________

____

Parent/Guardian Printed Name Signature

TO BE NOTARIZED AS APPROPRIATE:

STATE OF ______________________________

COUNTY OF ____________________________

BE IT REMEMBERED THAT ON THIS _______ day of ______________________, 20______, before me, the undersigned, a Notary Public in and for the County and State aforesaid, came ____, who is personally known to be the identical person who signed the above foregoing Consent and Medical Authorization, and acknowledged to me that he/she signed the same freely and voluntarily and knew the purpose for which said statement was to be used.

IN TESTIMONY WHEREOF, I have hereunto affixed my official seal and signature the day and year last written above.

My appointment expires: _____________________________________

Signature of Notary Public: ____________________________________

Consent of Parent/Guardian- Medical Care and Treatment Form

Student Name:		DOB:
Parent/Guardian Names:		
Telephone (H)	(W)	(C)
Home Address:		
City:	State:	Zip:
Name of Medical Provider:		Telephone:
Address:		
City:	State:	Zip:
If you or the medical provider cannot be notified, in an emergency notify:		
Name:		Telephone:
Address:		
City:	State:	Zip:
Health Insurance Company:		Telephone:
Address:		
City:	State:	Zip:
Policy Number:		Group Number:

Current Medications	Dietary Restrictions

Circle any of the following that apply to the student:

Asthma	Anaphylaxis	Seasonal Allergy	Diabetes	Heart Condition
Seizures	Fainting	Anxiety	Depression	Digestion Issue
Acid Reflux	ADD/ADHD	Hypothyroid	Hypoglycemia	Migraines

Other: ____

Health Statement

Allergies and Reaction:

Recent Health Concerns:

Medication Policy

The delegated USD 320 staff member will provide care and dispense medications for the students on the field trip in accordance with the policies of the USD 320 Wamego school district.

- Parents may administer medications to **their own children** whether they are controlled substances, emergency medications, or over-the-counter medications.
- **Parents/chaperones ARE NOT to dispense ANY medication (even over-the-counter medications) to any student other than their own student at any time.**
- All prescribed medications should be brought to the delegated USD 320 staff member for review.
    - Please list medications below in section A
- Many medications prescribed for attention deficit disorder and other reasons including depression, are controlled substances. **Controlled substances will be dispensed by the**

delegated USD 320 staff member. The prescription bottle will serve as direction from the doctor for the trip.

    - Parents must complete authorization and list medication in Section B below
    - **Please only send enough medication for the week.** The delegated staff member will safeguard these medications during the trip.

- Students with asthma or severe allergies may carry and self-administer emergency medications such as inhalers and epinephrine.
    - Please list medications below in Section A
    - **Parents are responsible for supplying these medications.**
- Over-the-counter medications (Tylenol, Ibuprofen, cough drops, etc.) may be carried and self-administered by students without written parent and/or physician signature. A limited supply of over-the-counter medications may be available for students from a delegated USD 320 staff member upon parent permission. Additionally, antibiotics may be self-carried and self-administered by the student.
    - You may complete the form below in Section C to give permission for the delegated USD 320 staff member to administer over-the-counter medications to your student.
- **All medication must be carried in its original container.**
- **At no time should a student give medication to another student.**
- The principal or designated employee may revoke the self-medication privilege of any student found to be in violation of the policy.

I have read, understand, and will adhere to the medication policy as outlined above.

____

Parent/Guardian Printed Name Signature Date

____

Student Printed Name Signature Date

Student's Name: ___________________________ Date of Birth: _____________

Section A: List of Prescription Medications Student Will Carry:

Name of Medication	Dose	Time Taken	Reason for Medication

The above named student has been instructed on self-administration of medication, and I hereby give my permission for him/her to self-administer as ordered the medication(s) listed above. **I understand that it is my responsibility to furnish the medication.** I acknowledge that the delegated staff member incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and the school and its employees and agents, harmless against any claims relating to the self-administration of such medication.

____

Parent/Guardian Printed Name Signature Date

Section B: Medication to be Administered by the Delegated USD 320 Staff Member:

Includes ALL controlled substances and any prescription medications parents want the delegated USD 320 staff member to monitor.

Name of Medication	Dose	Time Taken	Reason for Medication

Student's Name: ____________________________ Date of Birth: _____________

Section C: Permission for Over-the-Counter Medications to be administered by the Delegated USD 320 Staff Member:

Please mark all that apply:

- ☐ Ibuprofen (Advil, Motrin) 200-400 mg dose
- ☐ Acetaminophen (Tylenol) 325-650 mg dose
- ☐ Zyrtec (Antihistamine) 10 mg dose
- ☐ Calcium Carbonate (Tums) 750-1500 mg dose

Authorization for prescription or above selected over-the-counter medications to be administered by a delegated USD 320 staff member

I grant permission for the delegated USD 320 staff member to administer medication/treatment to my child on the trip as indicated by my child's physician. I understand that I must provide any prescribed medication in its original labeled container and the pharmacy-generated prescription label will serve as direction from the doctor. I understand that any school employee who administers any drug or nonprescription medication to my student, as listed above pursuant to parental written request, in accordance with written instructions from the medical provider, shall not be liable for damages as a result of an adverse reaction suffered by the student because of administering such medication.

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Parent Signature Date