WEST DELAWARE HEALTH SERVICES

CONSENT TO RECEIVE PRESCRIPTION & OVER-THE-COUNTER MEDICATIONS

STUDENT_____GRADE_____

PHYSICIAN/PRESCRIBER_____PHONE_____

NAME OF MEDICATION_____

DIAGNOSIS_____

DOSAGE/ROUTE_____

TIME TO BE GIVEN_____

STARTING DATE_____ENDING DATE_____

SPECIFIC INSTRUCTIONS_____

I request that the prescribed drugs or medication be dispensed according to these written directions. I request that this medication be given by a qualified staff person. The student has experienced no previous side effects from the medication. I further 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 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.

PARENT/GUARDIAN SIGNATURE _____DATE_____

INHALERS

The 2004 Iowa Legislature enacted a law, signed by the governor, which allows students with asthma or other airway constricting diseases to self-administer medication at school (ex. Inhalers) with not only a signed parental consent but also the Physician's signature or a copy of the prescription.

NAME OF MEDICATION_____DOSAGE AND ROUTE_____

DIAGNOSIS AND SPECIFIC INSTRUCTIONS_____

PRESCRIBER'S SIGNATURE_____

COPY OF PRESCRIPTION ATTACHED_____

PARENT/GUARDIAN SIGNATURE _____DATE_____

WEST DELAWARE IS NOT RESPONSIBLE FOR MEDICATIONS NOT STORED IN THE HEALTH OFFICE