CONSENT AND REQUEST FOR MEDICATION ASSISTANCE DURING SCHOOL HOURS
Elko County School District School Health Services

Parent/guardians of students, who are required to take medication during school hours, must submit this completed form to the school health office. ***This applies to over-the-counter medication, as well as prescription medication***. All prescription medication must be in a current pharmacy labeled container. Non-prescription medication must be in the original packaging, labeled with the student's name and date of birth. **Any change in type, frequency or amount of medication will require a new form to be completed and signed by the physician/healthcare provider and parent.** If a student requires assistance with more than one medication, a separate form must be completed for each medication. Medications administered at school must be FDA approved.

PLEASE FAX THIS COMPLETED AND SIGNED FORM TO:

School Nurse: _____ **School:** _____

Phone Number: _____ **Fax:** _____

(If School Nurse contact information is not provided, please fax form to Elko County School District School Nurse Coordinator: 775 777-1195)

The undersigned physician/healthcare provider advises you that _____
Student Name

_____, requires assistance taking the following medication during the school day:
DOB

Name of Medication: _____

Dosage:_____ Route:_____ Time:_____ Start Date:_____ End Date:_____

Common Side Effects of Medication: _____

FOR "PRN" MEDICATIONS:
Symptoms/indications and frequency for giving the above medication: _____

_____

This medication will be provided to Elko County School District by the parent/guardian of the child and the undersigned parent/guardian agrees to assume all responsibility for maintaining the supply of medication. Medications that are kept in the school health office will be returned to the parent only, or with parent permission may be sent home with the student. Medications known as Controlled Substances cannot be transported by a student. Medications not claimed or picked up by the parent/guardian or their designee by the end of the last day of school will be disposed of by the School Nurse.

The undersigned parent/guardian hereby requests Elko County School District assist and supervise the above named student in taking the medication listed above during the school day. In addition, the parent/guardian gives permission to the School Nurse to exchange confidential information, relative to the medication noted above, with the undersigned physician/healthcare provider; and further agrees to hold the Elko County School District, the Board of Trustees of the District, and all agents of the District harmless from any liability for their participating in assisting and supervising the above named student in taking this medication.

_____
(Physician/Healthcare Provider, please print)

_____Date_____Phone_____
(**Signature of Physician/Healthcare Provider**)

_____Date_____Phone _____
(**Signature of Parent/Guardian**)

REVIEWED BY SCHOOL NURSE:

_____Date_____School _____
(**Signature of School Nurse**)

THIS CONSENT / ORDER IS VALID FOR ONE CALENDAR YEAR