

**CONSENT AND REQUEST FOR
MEDICATION ASSISTANCE DURING SCHOOL HOURS**

Parents/Guardians of students who are required to take any type of medication during school hours, with assistance from school personnel, must submit this completed form, including signatures, to the school health office. This applies to over-the-counter medicine, as well as prescription medicine. (The prescription label is not considered to be an order from a physician to allow school personnel to assist with medication).

All prescription medication must be contained in a current pharmacy container labeled with the student's name, physician's name, expiration date, medication, dosage, and frequency. Non-prescription medication must be in the original packaging, labeled with the student's name and date of birth. The amount of medication that will be kept at school will be determined in cooperation with the school nurse, parent and principal. **Any change in type, frequency or amount of medication will require a new form to be completed and signed by the physician and parent.** If a student requires assistance with more than one medication, a separate form must be completed for each medication.

PLEASE RETURN THIS COMPLETED AND SIGNED FORM TO THE SCHOOL NURSE AT THE APPROPRIATE SCHOOL

The undersigned physician advises you that (Student) _____ (Birthdate) _____ at (WCSD School) _____, requires assistance for taking the following described medication during the school day:

Name of Medication _____ Dosage _____ Route _____ Time _____

FOR "PRN" MEDICATIONS:

Symptoms or indications for giving the above medication: _____

Interval between doses: _____ Maximum number of doses per school day: _____

For school year _____ Start Date _____ End Date _____

This medication will be provided to the Washoe County School District by the parent or guardian of the child and the undersigned parent or guardian agrees to assume all responsibility for maintaining the supply of the medication and replacing such medication when its effectiveness has lapsed by reason of time. Medications that are kept in the school health office may not be sent home with students. Medications not claimed or picked up by the parent/guardian or their designee by the day following the last day of the school year will be disposed of by the school nurse or her designee.

The undersigned parent or guardian hereby requests the Washoe County School District to assist and supervise the above-named student in taking the above described medication, as set forth, and consents to such assistance and supervision during the school day. In addition, the parent or guardian hereby gives permission to the school nurse at the above described school to exchange confidential information, relative to the medication noted above, with the undersigned health care provider or physician; and further hereby agrees to hold the Washoe County School District, the Board of Trustees of the District, and all agents of the District harmless from any liability for their participation in assisting and supervising the above named student in taking this medication.

(Signature of Physician) Date _____ Phone _____

(Signature of Parent/Guardian) Date _____ Phone _____

REVIEWED BY SCHOOL NURSE:
_____ Date _____ School _____

THIS CONSENT AND REQUEST EXPIRES AT THE END OF THE SCHOOL YEAR