Washoe County School District
Student Health Services
Fax: 775-353-5968

Student ID _____

CONSENT AND REQUEST FOR MEDICATION ASSISTANCE DURING SCHOOL HOURS

In order to receive assistance by WCSD personnel with medication administration, a student must have this completed form, including signatures, on file in the school health office. This applies to over-the-counter as well as prescription medication. A prescription label ***is not considered*** an order from a physician or authorized medical provider.

All prescription medication must be in a current pharmacy container labeled with the student's name, the name of the physician or authorized medical provider, 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 co-signed by the 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 student's school.

This section is to be completed by the HEALTH CARE PROVIDER

The following student requires assistance during the school day, taking the medication described below:

Student Name: _____ Date of Birth: _____WCSD School: _____

Name of medication: _____ Dosage: _____Time(s):_____

Route: ◯ Oral ◯ G-Tube ◯ Inhaler ◯ Nebulizer ◯ Other _____

- **For *PRN medications*, please complete the following:**

Criteria and/or symptoms requiring medication administration:
_____

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

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 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.

Physician Name (print) _____

Physician Signature _____ Date _____ Phone _____

Signature of Parent/Guardian: _____ Date _____ Phone _____

REVIEWED BY SCHOOL NURSE: _____ Date _____

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