Student Health Services

Student ID_____

# Parent/Guardian Consent for Medication Assistance during School Hours

(for medication with a current prescription label)

Student Name: _____DOB: _____School Year: _____

School: _____Medication(s):_____

1. I have made every effort to avoid the necessity of requesting Washoe County School District (WCSD) to assist my student with medication during the school day and sponsored activities.
2. I have been offered a copy of the WCSD Assisting Students with Medication Procedure (HEA-P200) and have been given the opportunity to ask questions.
3. I am aware that the medication will be given in accordance with the current prescription(s) from the licensed healthcare provider.
4. If student's medical condition changes or if the licensed healthcare provider changes, I will notify the school nurse.
5. I understand that I am responsible for providing and maintaining a supply of the medication(s) to be given by the WCSD to my student.
6. All prescription medication must be in a pharmacy container with current, accurate pharmacy label in place.
7. If medication prescription changes in any way, a new label or written prescription from a licensed healthcare provider is required.
8. If the medication appears different in any way, when refilled, the medication will not be given, and the parent/guardian will be contacted.
9. I give permission to the school nurse to exchange confidential information or get clarification, relative to the medication(s) noted above, with the prescribing licensed healthcare provider or pharmacist pursuant to NCA 632.220*.
10. Parents can send medication to school with their student that is to be kept in the clinic, WCSD employees cannot send medications home, with the exception of insulin, epinephrine autoinjectors, and albuterol inhalers.
11. If medication expires or has not been picked up by the last day of school, the medication will be disposed of by WCSD staff.

Note: *Pursuant to NAC 632.220, as a condition of providing care as related to this form, a registered nurse may contact the licensed healthcare provider or associates regarding the verification of an order given for the care of a patient to ensure that it is appropriate and properly authorized and that there are not documented contraindications in carrying out the order.

Parent/Guardian further hereby agrees to release, defend, indemnify and hold harmless the Washoe County School District, the Board of Trustees of the Washoe County School District, and all employees and agents of the Washoe County School District from any claims or liability for the Washoe County School District's participation in assisting and supervising the above named student in taking this medication.

**THIS REQUEST EXPIRES AT THE END OF THE SCHOOL YEAR.**

| _____ | _____ | _____ |
|---|---|---|
| Parent/Guardian Signature | Parent/Guardian Name (Print) | Date |

_____

Parent/Guardian Phone Number

| _____ | _____ | _____ |
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| School Nurse Signature | School Nurse Name (Print) | Date |