Dickenson County Parental Consent and Licensed Prescriber Authorization for Administrating Medication

PARENTAL CONSENT

Students Last Name: _____First:_____
Grade: _____Date of Birth: _____/___/_____ Allergies_____

Parental Consent: I am the parent/guardian of_____, I give permission for him/her to take the following prescribe medication while in the Dickenson County School System. I hereby acknowledge that I have read and understand the Dickenson County Public School handbook on page 32 "**Administering Medication to Student".** In the absence of the school nurse, trained personnel will administer medication such as, but not limited to glucagon, epinephrine and insulin. I hereby release Dickenson County Schools and its employees from any claims or liability connected with its reliance on such reliance. I authorize a representative of the school to share information regarding this medication with the licensed prescriber.

Parent/Guardian Signature _____Date_____
Daytime Phone_____

MEDICATION AUTHORIZATION

Relevant Diagnosis: _____

Medication: _____
Dosage: _____Route: _____Time(s) of Day: _____

Duration of order: _____
Serious reaction/adverse side effects form this medication may occur: _____
Describe: _____
Action/treatment for reaction_____

Licensed Prescriber's Name: _____
Telephone Number: _____
Licensed Prescriber's Signature: _____