Cloudcroft Municipal Schools
Health Services
Medication Consent Form

Name of Student _____ Date of Birth _____ Grade _____

I give my permission for the school nurse to supervise the administration of the medication(s) prescribed by my doctor and listed below. I understand that it may be necessary for the registered nurse to consult the physician regarding these orders. I give consent for the registered nurse to consult the physician, if necessary. I will be notified, if this is necessary.

I understand that it is essential that the school nurse (registered nurse) be notified of all students taking medications at school. Because the school nurse is not always available to give the medication required by all children, the principal will authorize another school employee to supervise the actual administration of the medication in the absence of the registered nurse, with the exception of syringe/needle administered medications.

I understand that it is my responsibility to provide this medication in a container that is properly labeled. Prescription drugs will require the original bottle/box with the pharmacy label. Over the counter medications will require the original bottle with the label.

Recognizing that Cloudcroft Municipal School is under no obligation to administer medication, I hereby waive any claim for injury against Cloudcroft Municipal Schools, or its employees, arising from the administration or lack of administration of such medication.

Furthermore, I agree to indemnify Cloudcroft Municipal Schools and its agents and employees for any claims, suits, judgments or costs of defense (including attorney's fees) arising from any such claims.

Parent/ Guardian Signature _____ Date _____

To Be Completed By the Physician

It is necessary that _____ receive the below listed medication(s) during school hours:

Medication	Dosage/Route	Time	Reactions

PLEASE INITIAL BOXES

☐ If the AM dose is missed, it may be given as needed, w/ parent/guardian consent.
☐ Student has been instructed on the proper use of an inhaler.
☐ Student's medical condition necessitates that they carry their medication, at all times.

These medication(s) shall be administered :

☐ SELF- SUPERVISED ☐ SELF- UNSUPERVISED ☐ ADMINSITERED BY NURSE IF PRESENT

Physician's Signature _____ Phone# _____ Date _____