

**DICKINSON PUBLIC SCHOOL  
NON-SELF ADMINISTERING MEDICATION CONSENT FORM  
(PHYSICIAN'S SIGNATURE REQUIRED)**

**FOR ANY MEDICATION THAT WILL BE ADMINISTERED BY SCHOOL STAFF INCLUDING:** Prescription medication or Over-the-counter medication if it is to be provided in a manner inconsistent with manufacturer's recommendation.

Name of Student \_\_\_\_\_ D.O.B. \_\_\_\_\_  
 Address \_\_\_\_\_ School \_\_\_\_\_  
 Parent/Guardian's Name \_\_\_\_\_  
 Phone- Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_  
 Emergency Contact (other than parent) \_\_\_\_\_  
 Phone- Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_  
 Health Care Provider Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

**Health Care Provider Section**

Diagnosis \_\_\_\_\_  
 Name of medication/treatment \_\_\_\_\_  
 Dose \_\_\_\_\_  
 Time(s) to be administered at school \_\_\_\_\_  
 Method (route) of administration:  
 Mouth  Eyes  Ears  Nose  Topical (eg. Skin ointment)  
 Other (If other, check with school administration to determine if school is able to accommodate)  
 Medication to be administered from \_\_\_\_\_ to \_\_\_\_\_ (Month/Day/Year)  
 Precautions and reactions to observe and report to parent/physician: \_\_\_\_\_  
 \_\_\_\_\_  
 Student Allergies \_\_\_\_\_  
 Comments \_\_\_\_\_

I certify that the information contained on this form is accurate and complete to the best of my knowledge.

\_\_\_\_\_  
 Healthcare Provider's Name (please print)      Health Care Provider Signature      Date

**PARENTAL CONSENT**

**I authorize my child to receive the above medication while at school and relieve the school district and personnel of all responsibility. I authorize the school's designated medication provider to provide the medication to my child. I acknowledge that I have read, understand, and agree to comply with the School District's medication program policy. I certify that medications I have authorized the school to provide to my child do not, to my knowledge, interact, and I certify that my child is not known to be allergic to them. I certify that the information included on this form is accurate to the best of my knowledge. I understand and hereby release Dickinson Public School District and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance.**

\_\_\_\_\_  
 Name of Parent/Guardian (please print)      Signature of Parent/Guardian      Date

**\*\*\*\*One medication per form**

**\*\*\*New form required each time the student has a new medication or if there is a change in the student's current medication.**

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## DICKINSON PUBLIC SCHOOLS

### CONFIDENTIALITY WAIVER

*NOTE: Completion of this section by a parent/guardian authorizes the disclosure and/or use of your child's individually identifiable health information consistent with law (including HIPAA/FERPA).*

I \_\_\_\_\_ (parent/guardian's name) authorize (name of agency and/or health care providers): \_\_\_\_\_

to provide health information from \_\_\_\_\_ (student's name) medical record to: \_\_\_\_\_ (name of school).

The disclosure of health information is required for the school to provide medication and/or oversee my child's self-administration of medication.

Requested information shall be limited to the following:  All minimum necessary health information; or  
 Disease/condition-specific information as described:

\_\_\_\_\_ This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_ (enter date) or for the remainder of the school year.

Law prohibits the school from making further disclosure of my child's health information unless the school obtains another authorization form from me or unless such disclosure is specifically required or permitted by law. I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me, and delivered to the healthcare agencies/persons and school listed above. My revocation will be effective upon receipt but will not be effective to the extent that the school or others have acted in reliance of this authorization.

I understand that the school will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the school for the purpose of providing safe, appropriate, and least-restrictive educational settings and school health services and programs.

I have a right to receive a copy of this authorization. Signing this authorization is required in order for my child to obtain medication services in the educational setting.

\_\_\_\_\_  
Parent/guardian's signature

\_\_\_\_\_  
Date

**NOTE: A copy of this confidentiality waiver must be sent to the student's healthcare provider upon completion**

End of Dickinson Public School District Exhibit ACBD-E2