

WHITE PINE COUNTY SCHOOL DISTRICT

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HEALTH SERVICES DEPARTMENT

HEATHER WILLIAMS RN BSN CHIEF DISTRICT SCHOOL NURSE

CONSENT AND REQUEST FOR ORAL MEDICATION DURING SCHOOL

The undersigned physician advises you that _____, a certified student of the White Pine County School District, requires the following described medication during the school day:

MEDICATION: _____ **DOSE:** _____

TIME TO BE ADMINISTERED: _____

ANY OTHER INSTRUCTIONS: _____

This medication will be provided to the White Pine County School District by the parent/guardian of said student and the undersigned parent/guardian agrees to assume all responsibility for maintaining the supply of said medication and replacing such medication when its effectiveness has lapsed by reason of time.

The undersigned parent/guardian hereby requests the White Pine County School District, through Health Services and/or school staff to administer to said student the above prescribed medication during the school day. Said parent/guardian hereby expressly relieves the White Pine County School District, the Board of Trustees of the district and all agents of the district from any liability for the administration of such medication, and further hereby agrees to hold the White Pine County School District, the Board of Trustees of the district and all agents of the district from any liability for the administration of such medication, and further hereby agrees to hold the White Pine County School District, the Board of Trustees of the district, and all agents of district harmless from any liability for the administration of such medication.

(MD, DO, APRN, PA) WRITTEN NAME: _____

(MD, DO, APRN, PA) SIGNATURE: _____ **DATE:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

*I give permission for the school nurse to discuss with the above named MD, DO, APRN, or PA any observations of effects on my student in relation to the above medication or changes in my student as a result of said medication.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

REVIEWED/APPROVED BY SCHOOL NURSE: _____ **DATE:** _____

PRINCIPAL: _____ **DATE:** _____