

XAVIER HEALTH PROMOTION CENTER

6300 42nd Street NE Cedar Rapids, IA 52411 Telephone: (319) 294-6635

CONSENT TO RECEIVE PRESCRIPTION & OVER-THE-COUNTER MEDICATIONS

STUDENT _____ GRADE _____

PHYSICIAN/PRESCRIBER _____ PHONE _____

NAME OF MEDICATION _____

NAME OF PHARMACY _____

DIAGNOSIS _____

Please give the above medication:

AMOUNT _____

TIME OF DAY _____

STARTING DATE _____ ENDING DATE _____

AMOUNT SENT _____

I request that the prescribed drugs or medication be dispensed according to these written directions. I request that this medication be given by a qualified staff person. The student has experienced no previous side effects from the medication. I further agree that school personnel may contact the prescriber as needed and that medication information may be shared with school personnel who need to know.

I understand the law provides that there shall be no liability for damages as a result of the administration of medication where the person administering the medication acts as an ordinary reasonably prudent person would under the same circumstances and that the school district and the school nurse are to incur no liability, except for gross negligence, as a result of injury arising from the administration of medication.

PARENT/GUARDIAN _____

SIGNATURE _____

DATE _____ HOME PHONE # _____

WORK PHONE # _____

MEDICATION WILL NOT BE GIVEN IF IT HAS EXPIRED OR IT HAS AN IMPROPER LABEL. PLEASE CHECK THE CONTAINER BEFORE SENDING IT TO SCHOOL.

SUGGESTION: WHEN YOU PICK UP YOUR CHILD'S PRESCRIPTION ASK YOUR PHARMACIST FOR A BOTTLE LABELED FOR SCHOOL USE.

PERMISSION FOR DISPOSAL OF MEDICATION

I will pick up my student's medication within 1 week of last day of school.

Discard any remaining medication

If any medication is left after the last day of school, it will be discarded 1 week after school is out for the summer.

Xavier High School is not responsible for medications not stored in the Health Promotion Center.