Campbell County School District #1
Nursing Services

School Nurses Campbell County

Medication/Treatment Permission

Student Name:	School:	Photo:
Date of Birth:	Grade/Teacher:	
Medication/Treatment:		
Dosage:	Route:	
Purpose of Medication/Treatment:		
Time to be given at school:	Frequency (e.g. daily):	Note Special storage requirements ☐None ☐Refrigerate ☐Other (please specify):
Anticipated number of days medication/treatment will be given at school: ☐ Until the end of the current school year ☐ _____ weeks ☐ _____ days	Is child allergic to any food, medicines, or other items: ☐No ☐Yes(list allergies):	
Special considerations/instructions:		
Possible side effects:		
Prescribing Healthcare Provider Name:		

_____ _____
Prescribing Healthcare Provider Signature Date

***Healthcare provider signature is required if medication/treatment will be administered at school for longer than 30 days.

PARENT CONSENT
I hereby give permission for my child to be given this medication/treatment at school as stated above. I understand it is my responsibility to provide medications and supplies including the secure transport and delivery of this medication to school. I authorize the school nurse and healthcare provider office to communicate regarding my child's diagnosis and treatment.

_____ _____
Parent Signature Date

Complete Medication Administration regulation may be viewed on District web site:
http://www.campbellcountyschools.net/

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Field Trips

Campbell County School District students may go on field trips throughout the year. There may be a possibility that the field trip would fall during a time that a medication/treatment needs administered.

If my child needs their medication or treatment during a field trip, I choose the following option for my child:

____ I will arrange an adjusted time with the school nurse for the medication/treatment to be given to my child either before or after the field trip.

____ I choose **NOT** to have my child receive his/her medication/treatment on the day of the field trip.

____ I give permission for my child to have a duly authorized agent of the school district administer his/her medication/treatment on the field trip.

All school policies, rules, and regulations pertain to this trip. I hereby authorize Campbell County School District and its faculty members in charge of my child to obtain all necessary medical care for my child in the event that I cannot be reached to authorize it myself. I hereby authorize any licensed healthcare provider and/or medical personnel to render necessary medical treatment to my child.

_____ _____

Parent/Guardian Signature Date

Date	Current Med Count	New Med Count	Parent/Witness Signature	Nurse Signature	Comments