



KENNEDALE INDEPENDENT SCHOOL DISTRICT  
Medication Consent Form

**Parent/Guardian:**

I hereby request that the following medication specified below be administered to my child. I understand and will comply with the school's policies and procedures regarding medication administration (policy included on the following page). I understand that unexpected consequences including, but not limited to, illness, adverse reactions or other complications may occur as a result of the administration (or non-administration) of any medication. The first time any medication is given; it must be administered at home by the parent to observe for any side effects. By requesting and consenting to the administration of medication to your child, you are assuming the risk of an unexpected reaction may occur and understand that Kennedale ISD and employees will not be held responsible.

Student Name: _____	DOB: _____	Campus/Grade: _____
Parent/Guardian's Name: _____	Phone: _____	
Email: _____		
Date: _____	Parent/Guardian's Signature: _____	
<b>Student and parent are aware of the medication policies.</b>		

Diagnosis/Purpose of this medication: _____
Any known allergies: <input type="checkbox"/> NO <input type="checkbox"/> YES Please list. _____
Name of Medication: _____ Strength (i.e. 10 mg/tab): _____
Dose (i.e. # of tabs, tsp, oz, ml, puff): _____ Time (i.e. 11 am, lunch, PRN): _____
Frequency (i.e. q 4 hrs): _____ Duration (i.e. 10 days, school year): _____
Comments: _____
Name/Strength of Medication Sent _____ Quantity Sent _____ Parent Initials _____

Is student authorized to carry the INHALER/EPI-PEN with them? ( <b>RESCUE MEDS ONLY</b> )	<input type="checkbox"/> NO <input type="checkbox"/> YES
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HEALTHCARE PROFESSIONAL SIGNATURE REQUIRED FOR: ALL prescription medications and over-the-counter medications for elementary and intermediate (only parent signature for secondary schools)

Healthcare Practitioner's PRINTED NAME: _____
Healthcare Practitioner's Signature: _____ Date: _____
Office Phone: _____ Office Fax: _____

CAMPUS	FAX NUMBER	CLINIC PHONE NUMBER
High School	817-563-3718	817-563-8120
Junior High	817-483-3655	817-563-8220
Arthur Intermediate	817-483-3628	817-563-8320
Delaney Elementary	817-483-3653	817-563-8420
Patterson Elementary	817-483-3638	817-563-8620

<b>FOR NURSE'S USE ONLY</b>			
504 _____	SPED _____	If so notify Diagnostician _____	
Date Orders Rec'd _____	Date/Time Med Rec'd _____	Medication Rec'd _____	Quantity Rec'd _____
Lot # _____	Expiration Date _____	Nurse _____	



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**ALL Medications:**

1. PARENT/GUARDIAN MUST SUPPLY ALL MEDICATIONS; SCHOOL PERSONNEL WILL NOT PROVIDE MEDICATION FOR ANY STUDENT
2. Medications **must** be in the ORIGINAL container and have a current label
3. Medications in baggies or combination of medications in the same bottle will not be accepted
4. The pharmacy will supply two bottles when requested one for home and one for school
5. "As needed"/PRN medications must also meet these requirements
6. Each medication must be on a separate form
7. Medications must be picked up by an adult and may not be transported home by the student. Medications left after the last day of school will be discarded and not be kept over the summer
8. Medication forms must be updated each school year
9. The school nurse cannot be expected to diagnose a condition or to select the correct medication to administer

**PRESCRIPTION Medications:**

1. Once or twice daily (every 12 hours) medications can be given before school and after school, three times a day (every 8 hours) medications can be given before school, after school and at bedtime and do not need to be given at school.
2. The requesting physician or dentist must state the dosage and reason for administering the medication.
3. Prescription medications must be kept in the clinic for administration by the nurse
4. A medication administration form must be completed and signed by the parent AND physician.

**OVER-THE-COUNTER/NON-PRESCRIPTION Medications:**

**A. Elementary and Intermediate Campuses**

1. Medication must be kept in the school clinic for administration by the nurse
2. A medication administration form must be completed and signed by the parent AND physician.

**B. Junior High Campus**

1. Medication must be kept in the school clinic for administration by the nurse
2. A medication administration form must be completed and signed by the parent ONLY

**C. High School Campus**

1. Students may carry non-prescription medications with them if:
  - ◆ The form Self Administration of Non-Prescription Medications at Schools must be completed and signed by the parent/guardian
  - ◆ Students must have written permission from their parent to have the medication and they must keep the note and medication together.
  - ◆ Students are not to share medication with other students.
  - ◆ Medications in baggies or mixture of medications in one container will be confiscated by school personnel and destroyed.
2. The medication may be kept in the school clinic if the parent prefers; the medication administration form must be completed and signed by the parent ONLY

**EXPIRATION DATES**

1. Expired medications will not be given
2. Check the date of expiration for inhalers and epi-pens and try to supply one that does not expire during the school year if possible.