UNION ACADEMY
Challenge. Character. Community.

Union Academy Charter School
Dr. Ann Walters, Headmaster

Nursing Department – Medication Consent Form

To be completed by Physician/Parent:

Student Name: _____ D.O.B: _____ Teacher/Grade: _____

Name of medication (one medication per consent form): _____

Medication must be brought to school by the parent/guardian (students are not authorized to transport medication). Medication must be in the original container, labeled with child's name, and not expired.

Scheduled Medication:

Dosage to be given: _____ Time(s) to be given: _____

Purpose of the scheduled medication: _____

As Needed Medication:

Dosage to be given: _____ Time(s) to be given: _____

Symptom for which medication may be given: _____

Self-Carry Medication: Student are only permitted to carry; Epi Pen, Insulin, Glucagon, and/or Emergency Inhaler. "Self-Carry Medication Authorization Form" must be completed, and submitted with "Medication Consent Form".

***** All medications must be kept in the health room (except approved Self-Carry Meds)*****

Physician's and Parent signature is required for ALL medication, prescription or over-the-counter.

_____ _____
Physician Name (Please Print) **Physician Signature**

(_____) _____ (_____) _____ _____
Physician Phone **Physician Fax** **Date**

I hereby give permission for my child, named above, to receive medication during school hours, during the after school program, during athletic events or practices, and during field trips. I also give the school nurse or athletic trainer permission to contact the prescribing physician with any questions or concerns. I hereby release Union Academy and their agents from all liability that may result from my child taking this medication.

_____ (_____) _____ _____
Parent/Legal Guardian Signature **Daytime Phone** **Date**

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Nursing Department –
Student Self-Carry Medication Authorization Form
Emergency Medications

Student Name: _____ Date of Birth: _____

Medication: _____ Administer For: _____

This form is for students with asthma, diabetes and/or severe allergies who may require emergency rescue medications (inhaler, insulin, glucagon, or epi-pen).

Healthcare Provider: This student is capable of and has been instructed on how to self-administer this medication as directed on the medication consent form (both correct technique and dose intervals). Please allow him/her to self-administer it during school hours or activities.

This student will not require adult supervision while taking this medication.

Healthcare Provider Signature: _____ **Date:** _____

Parent/Guardian: I give consent to Union Academy Charter School to allow my child to self-administer this medicine at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medicine. I absolve the Union Academy School Board and their agents from any and all liability whatsoever that may result from my child taking this medicine at school.

Parent/Guardian Signature: _____ **Date:** _____

Student: I am capable of taking this medicine as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to disciplinary actions if medications are shared. I will inform an adult when the emergency medication is used.

Student Signature: _____ **Date:** _____

School Nurse: I have reviewed this request and agree that this student should be capable of safely self-administering this medication.

Union Academy Nurse Signature: _____ **Date:** _____