Leander ISD Off-Campus Medication Consent
(2021-2022 / Vandegrift HS Band)

Name of Student: _____DOB: _____ Age: _____ Grade: _____

List any/all allergens (ex. drug/food/environmental): _____

List medical conditions (asthma, contacts, etc.): _____

Non-Prescription / Over-the-Counter (OTC) Medication Authorization

I request and will supply the following Over-the-Counter Medication to be administered to my student. I understand that the School District, the Board, its employees and trained chaperones shall be immune from civil liability due to allergic reaction or other injuries resulting from the administration of medication to a student, provided such administration conforms to the requirements of this policy.

Name of Medication: _____ Exp. Date: _____ Dosage:_____

Time(s) to be given at school: _____ Do not administer after the following date: _____

Parent/Guardian Printed Name: _____ Parent/Guardian Signature: _____

Home: _____ Work: _____ Cell: _____

Date: _____

Prescription Authorization

I request that trained LISD staff or a trained chaperone administer medication/s listed below to my student according to the physician's instructions. I agree to furnish an adequate amount of medication in the original container at the time of travel. I also give permission for the school to contact the below health care provider about the administration of this medication. I understand that the School District, the Board, its employees and trained chaperones shall be immune from civil liability due to allergic reaction or other injuries resulting from the administration of medication to a student, provided such administration conforms to the requirements of this policy.

Name of Student: _____DOB: _____ Age: _____ Grade: _____

Name of Medication: _____ Exp. Date: _____ Dosage: _____

Condition for which the medication is prescribed: _____

Time(s) to be given: _____ Do not administer after the following date: _____

Side effects:_____

Physician's printed name: _____ Physician's Signature: _____

Physician's Telephone: _____ Physician's Fax: _____ Date: _____

Parent/Guardian Printed Name: _____ Parent/Guardian Signature: _____

Home: _____ Work: _____ Cell: _____

Email address:_____ Date:_____