PICTURE

Leander ISD Off-Campus Medication Consent
(Insert – School Year / Campus Program)

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:____

Revised 2019