# SCHOOL DISTRICT OF SUPERIOR
## Parent/Guardian Medication and/or Procedure Consent Form

Full name of child: _____ Teacher: _____

Address: _____ Phone (home): _____ (work): _____

School: _____ Grade: _____ Birth date: _____

_____
Physician's name, address, phone number (who is ordering medication/procedure)

Name of medication/dosage or procedure: _____

Hour it is to be given: _____ Reason for medication/procedure: _____

I hereby give my permission to the nurse or delegate(s) to give the medication or perform the procedure to my child according to the written instruction of the doctor as shown on the Physician Order Form. I also hereby agree to give my permission to the school nurse to contact the child's physician.

I further agree to hold the School District of Superior and the school district's employee(s) who is (are) administering the medication or performing the procedure harmless in any or all claims arising from the administration of this medication or the performance of this procedure at school.

I agree to notify the school in writing at the termination of this request or when any change in the above orders is necessary.

_____ _____ _____
Signature of Parent or Legal Guardian | Printed name of Parent or Legal Guardian | Date

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