



Leander ISD Travel and Approved Over-the-Counter Medication Consent
School Year _____ / Campus Program _____

Participation in this program requires frequent travel for school events during the school year. Please provide the following information to be kept on file and keep the information up-to-date as needed.

Student Name: _____

I hereby give permission for my student to travel on transportation provided by Leander ISD to

_____ functions during the _____ school year.

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

If available, a First Aid kit, with the below approved OTC items, may be provided by the program booster club for minor ailments.

____ *(initial)* I **do not** give consent to staff to administer any non-prescription medication to my student.

____ *(initial)* I give consent to staff to administer non-prescription medications to my student as initialed below:

Please initial each medication that can be administered:

_____ Acetaminophen _____ Ibuprofen _____ Sore Throat Lozenges _____ Electrolyte

I hereby certify that my student has no known drug allergies _____ *(initial)*.

I understand that under the Texas Claims Act school districts have governmental immunity and are not liable for injuries that are not a direct result of negligent operation or use of a motor vehicle. I also understand that the School District, the Board, and its employees 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

Parent/Guardian: _____

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

Home: _____ Work: _____ Cell: _____

Emergency Contacts:

Name: _____

Home: _____ Work: _____ Cell: _____

Name: _____

Home: _____ Work: _____ Cell: _____

