LEANDER ISD
LEADING TO A BRIGHT FUTURE

Leander ISD Off-Campus Medication Consent
School Year_____
Campus Program_____

PICTURE

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, 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.

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 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, 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.

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:_____

Off-Campus Medication Documentation

Student Name:_____

DATE	MEDICATION	DOSE	# IN	DROPPED OFF BY	ACCEPTED BY	# OUT	PICKED UP BY

DATE	TIME	MEDICATON	DOSAGE GIVEN	ADMINISTERED BY SIGNATURE	COMMENTS

LISD Trained Staff Member Administering Above Medication Please Print & Sign Below

_____ / _____ _____ / _____ _____ / _____

_____ / _____ _____ / _____ _____ / _____