

**VANCOUVER PUBLIC SCHOOLS
CONSENT TO PARTICIPATE IN AFTER SCHOOL PROGRAM AND
MEDICAL TREATMENT CONSENT FORM**

THE UNDERSIGNED HEREBY GIVES PERMISSION AND AUTHORIZES _____
Student's Name

TO ATTEND THE FOLLOWING AFTER SCHOOL/EXTENDED DAY PROGRAMS _____

DATES OF ATTENDANCE _____

Consent for Medical Treatment

This is to authorize emergency medical care and treatment for my son/daughter in my absence. Every reasonable effort will be made to contact me if such action is necessary.

FAMILY PHYSICIAN

HOSPITAL PREFERENCE

NAME OF INSURANCE CARRIER

GROUP/CHART NUMBER

If your student will need to bring prescribed medication, the Authorization for Medication Administration form (enclosed) must be completed and signed by the health care provider and parent/guardian. For over-the-counter medications, please check with your school nurse for procedure.

DOES YOUR CHILD TAKE ANY MEDICATION? _____ If yes please list: _____

DOES YOUR CHILD HAVE ANY HEALTH CONCERNS THAT THE TEACHER NEEDS TO BE AWARE OF? _____

I UNDERSTAND THAT THE STUDENT WILL BE SUPERVISED BY SCHOOL AUTHORITIES AND THAT EVERY EFFORT WILL BE MADE TO ENSURE STUDENT SAFETY.

I WILL ASSUME FINANCIAL RESPONSIBILITY FOR EMERGENCY MEDICAL TREATMENT FOR MY CHILD.

PARENT/GUARDIAN SIGNATURE

DATE

EMERGENCY CONTACT NAME

PHONE/RELATIONSHIP

NOTE: THIS CONSENT FORM MUST BE SIGNED AND RETURNED TO SCHOOL PRIOR TO THE DESIGNATED DATE OF PROGRAMS ATTENDED.

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION IN VANCOUVER SCHOOL DISTRICT
(Excludes ointments, eye, nose or ear drops, suppositories and medication inhaled through the nose)

Student's Name: _____ School Year: _____
 DOB: _____ Gr.: _____ School: _____ School Fax: _____

THIS PORTION TO BE COMPLETED BY THE LICENSED HEALTH PROFESSIONAL (LHP)
PRESCRIBING WITHIN THE SCOPE OF THEIR PRESCRIPTIVE AUTHORITY

Name of Medication: _____		
Dosage/Frequency: _____		
Diagnosis or reason for medication: _____		
If given PRN, specify the length of time between doses: _____		
Possible major side effects of medication: _____		
What observable side effects do you want us to report: _____		
Student is capable of carrying/administering inhaler Yes <input type="checkbox"/> No <input type="checkbox"/> and/or Epi-pen Yes <input type="checkbox"/> No <input type="checkbox"/>		
I request and authorize that the above-named student be administered the above identified oral medication or Epi-Pen injection in accordance with the instructions indicated above from _____ to _____ (not to exceed current school year), as there exists a valid health reason which makes administration of the medication advisable during school hours.		
_____ Licensed Health Professional	_____ Clinic Name	_____ Date
_____ Name (Print or type)	_____ Telephone	_____ Fax

Please note:

1. Prescribed medication must be provided in the container labeled by the pharmacist with the name of your child, the name of the medication, the dosage and frequency in which the medication is to be given.
2. Over the counter medications must be in the original container.
3. If samples of medication are to be given, they must be labeled with the name of the student, dosage, and time to be given.
4. Medications must be brought to the school by the parent/ guardian.

THIS PORTION TO BE COMPLETED BY THE PARENT/ GUARDIAN

I request and authorize the school to administer medication to the above identified student in accordance with the health care provider's instructions. Confidentiality of information provided to my student's school district is protected by the federal Family Educational Rights and Privacy Act. I may revoke this authorization by writing to my student's school district. If I did, it would not affect any actions already taken by the school district based upon this authorization.	
Once health care information is disclosed, the person or organization who receives it may re-disclose it only in conformance with applicable confidentiality laws.	
You have my permission to communicate with this health care provider in order to make arrangements for the care and supervision of my child. I give the health care professional:	
Permission to fax this form to the school	<input type="checkbox"/> Yes <input type="checkbox"/> No
Permission for my student to carry and self-administer inhaler	<input type="checkbox"/> Yes <input type="checkbox"/> No
Permission for my student to carry and self-administer Epi-pen	<input type="checkbox"/> Yes <input type="checkbox"/> No
I understand the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student, and parents/guardians shall indemnify and hold harmless the district and its employees or agents against any claim arising out of the self-administration of medication by the student.	
_____ Parent/Guardian Signature	_____ Date of Signature