DESIGNATION AND ACCEPTANCE TO ADMINISTER MEDICATION

As a parent of a student _____ currently taking prescribed medication, I have designated and authorized _____to assist the student administering the medication in accordance with District Policy 3416. This designation and authorization include possessing the medication, providing it to the student at the appointed times, and confirming the student has ingested the medication.

I agree to accept responsibility for my student's receiving assistance from_____. This designation is strictly voluntary. Any negligence arising out of my designation shall be attributed to me as comparative negligence within the meaning of Section 27-1-702, MCA. I agree that my student will abide by any directives issued by_____ and failure to honor these directives may result in acceptance of this designation and authorization to be withdrawn and my being contacted to administer medication to my student.

This designation is in effect for the period of_____

Signature of Parent/Guardian:_____
Date:_____

Signature of Health Care Provider:_____
Date:_____

As the parent-designated adult, I agree to assist the student in administering the identified medication at the appointed times. I agree to possess the medication until it is needed. I understand the medication must be provided by the parent of the student. I confirm that I understand the method of possessing, ingesting, and timing as documented on this form. If a student refuses to comply with my directive as specified on this form, I will contact the parent or emergency contact immediately.

Signature of Employee:_____ Date_____

Medication:_____

Method of Possession:_____

Dosage Provided to Student:_____

Time and Frequency Provided to Student:_____

Method of Ingestion:_____

Additional Instructions:_____

In case of emergency, contact, and take following steps:

_____

_____

_____