CUMBERLAND SCHOOL DISTRICT
MEDICATION/TREATMENT ADMINISTRATION AND CONSENT FORM
453.4 EXHIBIT 1

PHYSICIAN'S ORDER

Name of Student: _____ DOB: _____

School: _____ Grade: _____

Name of Medication/Treatment: _____

Dosage & Time to be Administered: _____

Diagnosis: _____

Your signature on this document attests to your willingness and intent to direct, supervise, decide, inspect and oversee the administration of the medication by medically trained designees specified on this form, and that you will accept direct communication from them regarding the administration of the medication. We urge that all instructions be stated in language of the lay person.

Physician's Signature: _____ Date: _____

_____
(Name, Address, Phone Number, Fax Number of Physician Ordering Medication/Treatment)

Comments: _____

PARENT/GUARDIAN CONSENT

Name of Student: _____ DOB: _____

School: _____ Grade: _____ Teacher: _____

_____
(Name, Address, Phone Number of Physician Ordering Medication/Treatment)

Name of Medication/Treatment: _____

Dosage & Time to be Administered: _____

Reason for Medication/Treatment: _____

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

I further agree to hold the Cumberland School District and the school district's employees who are administering the medication or performing the treatment harmless in any or all claims arising from the administration of this medication or the performance of the 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/Guardian	Printed Name of Parent/Guardian	Date

THIS CONSENT IS VALID FOR THE CURRENT SCHOOL YEAR ONLY

Revised: June, 2013