



**Leander ISD Off-Campus Medication  
Consent (2023-2024 / Vandegrift HS Band)**

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, its employees and trained chaperones 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 or a trained chaperone 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, its employees and trained chaperones 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: \_\_\_\_\_