LEANDER ISD
LEADING TO A BRIGHT FUTURE

REQUIRED FOR EVERY STUDENT

Leander ISD Travel and Approved Over-the-Counter Medication Consent
(School Year_____ / Campus Program_____)

Participation in this program requires frequent travel for school events during the school year. Please provide the following information to be kept on file and keep the information up-to-date as needed.

Student Name: _____

I hereby give permission for my student to travel on transportation provided by Leander ISD to

_____ functions during the **(Insert School Year)** school year.

Non-Prescription /Approved Over-the-Counter (OTC) Medication Authorization

If available, a First Aid kit, with approved OTC items, may be provided for minor ailments.

____ ***(initial)*** I ***do not*** give consent to staff to administer any non-prescription medication to my student.

____ ***(initial) I*** give consent to staff to administer non-prescription medications to my student as initialed below:

Please initial each medication that can be administered:

_____ Acetaminophen _____ Ibuprofen _____ Sore Throat Lozenges _____ Electrolyte _____ Benadryl _____ Sunscreen

I hereby certify that my student has no known drug allergies _____ (initial).

List any/all allergens (ex. drug/food/environmental): _____

List medical conditions (asthma, contacts, etc.): _____

I understand that under the Texas Claims Act school districts have governmental immunity and are not liable for injuries that are not a direct result of negligent operation or use of a motor vehicle. I also 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

Parent/Guardian:

Printed Name:_____Parent/Guardian Signature:_____ Date:_____

Home: _____ Work: _____ Cell: _____

Emergency Contacts:

Name:_____

Home: _____ Work: _____ Cell: _____

Name:_____

Home: _____ Work: _____ Cell: _____

Approved Over-the-Counter Medication
Off-Campus Medication Documentation

Student Name:_____

DATE	TIME	MEDICATON	DOSAGE GIVEN	ADMINISTERED BY SIGNATURE	COMMENTS

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

_____ / _____ _____ / _____ _____ / _____

_____ / _____ _____ / _____ _____ / _____