SCHOOL DISTRICT OF PHILLIPS 453.4 – Exhibit 1

Parent/Guardian Medication Procedure Consent Form

Full Name of Child	
School	Date of Birth
Name of physician ordering medication or procedure	Phone number of physician
Address of physician ordering medication or procedure: ***Street**, City, State, ZIP*	

Name of medication or dosage or procedure	Reason for medication or procedure
Hour it is to be given	How it is to be given
Number of days medication is to be given	Starting Date

I hereby give my permission to the school personnel designated to give the medication or perform the procedure to my child according to the written instructions of the doctor as shown on the Physician Order form. I also hereby agree to give my permission to authorized school personnel to contact the child's physician.

I further agree to hold the School District of Phillips and the District employee(s) who is (are) administering the medication or performing the procedure harmless in any or all claims arising from the administration of this medication or the performance of this procedure at school.

I agree to notify the school at the termination of this request or when any change in the above orders is necessary.

Signature of Parent/Legal Guardian	Date Signed