Health Services

Parent Consent for Medication Administration & Medication Administration Plan

To be completed by Parent / Guardian:

Student Name____ DOB____________ School _________________________ Grade ________

Parent/Guardian Name ___________________________________ Best Contact # ___________________________________ (home, cell, work)

Other Person(s) to be notified in case of medication emergency _________________________________ Best Contact # __________________

Food / Medication / Other Allergies ____

Name of Medication / Treatment ____ Diagnosis _______________________________

To be completed by School Nurse:

Name of Licensed Prescriber ____________________________ Phone # ___________________ Emergency Phone # ____________________

Date Ordered ___________ Duration ________________ Dosage ____________ Frequency __________ Route of Administration_____________

Specific Directions for Medication Administration ____

Early Release Hold __________ Administer __________

Common Side Effects, Adverse Reactions ____

Delegated to (if applicable) ______________________________ Back-up Plans (if delegatee unavailable) _______________________________

Plan for Field Trips ____

Plans for teaching self administration, if applicable ____

Consent to Self-Administer Parent Yes ___ No ___ Licensed Prescriber Yes ___ No ___ (if the School Nurse determines it is safe and appropriate)

Persons to be notified of medication administration ____

Other medications being taken by the student (if not in violation of confidentiality) ____

Location where medication administration will occur Health Office _______ Other (specify) ____

Plan for monitoring medication, if needed ____

Please be aware there may be times before and/or after regular school hours that access to your child's medication may not be available. Please plan accordingly to have an extra supply available in case of emergency need.

I give permission to the School Nurse to share information relevant to the prescribed medication as he/she determines appropriate for my child's health and safety (including prescriber, prescriber's staff, school staff, child care provider, busing, and food services).

I understand I may retrieve the medication from the school at any time. I acknowledge that the medication will be destroyed if it is not picked up within one week following termination of the order or the last day of school.

Parent/Guardian Signature ________________________ **Date** _______ **Student's Signature, if appropriate** _________________ **Date** ______

School Nurse Signature ___________________________ **Date** _______