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 _____

To be completed by School Nurse:

Name of Medication / Treatment _____ Diagnosis _____
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 _____