JEFFERSON PARISH SCHOOLS

PARENT / GUARDIAN WRITTEN CONSENT FOR MEDICATION ADMINISTRATION

Name of Student _____ Date of Birth _____ Sex _____

Name of Parent / Guardian _____ Relationship _____
Please Print

Address _____ Home Phone _____

Work Phone- Mother _____ Father _____ Beeper/Cell Phone _____

Other Persons to be notified if parents / guardian are unavailable:

_____ Home Phone _____ Work _____
Name Relationship

_____ Home Phone _____ Work _____
Name Relationship

My son / daughter is currently receiving the following medications at home:

1. _____ 2. _____
Medication Dosage Time Medication Dosage Time

3. _____ 4. _____
Medication Dosage Time Medication Dosage Time

Food / Drug Allergies: _____

I hereby give my permission for the school nurse or designated unlicensed school staff member to give the following:

1. _____ 2. _____
Medication Dosage Time Route Medication Dosage Time Route

3. _____ 4. _____
Medication Dosage Time Route Medication Dosage Time Route

prescribed by _____ to _____
Name of Doctor or Licensed Provider Name of Student

Special instructions: _____

I have administered the first dose at home to my child and have allowed time for observation of adverse reactions before asking school personnel to administer the medication.

I give my permission for the school nurse to contact my child's physician and the use of electronic communication regarding my child's medical needs.

I give my permission to the school nurse to share with appropriate school personnel information (such as the name of the medication, the adverse side effects) relative to the prescribed medication administration as the nurse determines necessary for my son's / daughter's health and safety.

I give my permission for my son / daughter to self –administer his / her medication if the school nurse determines it is safe and appropriate in the school. Yes _____ No _____

I understand that I may personally retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within 7 days following the termination of the physician's order or 7 days beyond the end of the current school year.

I have read, understand and agree to the SCHOOL'S MEDICATION POLICY IN THE STUDENT HANDBOOK. Date: _____

_____ Signature: _____ Relationship: _____

Revised 4/19