TANGIPAHOA PARISH
SCHOOL SYSTEM

NURSING SERVICES

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PARENT/GUARDIAN REQUEST AND AUTHORIZATION FOR MEDICATION ADMINISTRATION

STUDENT GENERAL INFORMATION

STUDENT: _____ **SCHOOL:** _____
DATE OF BIRTH: _____ **SEX:** _____ **GRADE:** _____ **TEACHER:** _____
PARENT/GUARDIAN: _____
PHONE NUMBER: (Home) _____ **(Work)** _____ **(Cell)** _____
Other Persons to Be Notified In Case Of Emergency if Parent/Guardian Is Unavailable:
NAME: _____ **PHONE:** _____**RELATIONSHIP:** _____
NAME: _____ **PHONE:** _____**RELATIONSHIP:** _____

STUDENT MEDICAL INFORMATION

DIAGNOSIS: _____
MEDICATION: _____
PRESCRIPTION #: _____**DISCONTINUED DATE:** _____
DOSAGE: _____
FREQUENCY: _____ **TIME:** _____ **ROUTE:** _____
DESIRED EFFECT OF MEDICATION: _____
OTHER MEDICATIONS STUDENT RECEIVES (taken at home and school):

1._____ **2.**_____ **3.** _____ **4.**_____ **5.** _____

CONSENT

1. **I request and give permission for the school nurse and/or trained unlicensed school employee to administer the following medication** _____**to** _____**prescribed by**_____**. YES ___ NO ___**
   (name of medication) (name of student) (name of doctor)
2. **I give permission for the school nurse to obtain information relative to the prescribed medication from the above named physician and share it with appropriate school personnel (such as adverse effects). YES ___ NO ___**
3. **I have administered the initial dose of the medication at home and have allowed sufficient time for observation of adverse reactions before requesting school personnel to administer the medication. YES ___ NO ___**

STUDENT SELF-ADMINISTRATION OF MEDICATION

Complete for students who will carry and administer their own medication.

Do you give permission for your son/daughter to carry/self-administer medication if the doctor and school nurse determines it is safe and appropriate in the school setting? YES_____ NO_____
Do you feel that your child is sufficiently responsible and informed to administer his/her own medication at school? YES_____ NO_____
Do you assume responsibility for your child's actions in his/her self-management of medication at school? YES_____ NO_____

I, _____**the parent/guardian of** _____ **acknowledge that the school**
(please print) (student name)
and its employees shall incur no liability and I shall indemnify and hold harmless the school and its employees against any claims that may arise relating to the self-administration of medications.

SIGNATURE OF PARENT/GUARDIAN_____ **DATE** _____
SCHOOL NURSE_____ **DATE** _____