JEFFERSON PARISH PUBLIC SCHOOL SYSTEM
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 5/08