

**JEFFERSON PARISH PUBLIC SCHOOL SYSTEM
PARENT/GUARDIAN WRITTEN CONSENT
FOR SELF-ADMINISTRATION OF INSULIN**

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: _____

1. I hereby give my permission for _____ to self-administer
Name of student

Name of insulin

prescribed by _____
Name of Doctor

Special instructions: _____

2. My child has been instructed and determined capable by the physician to self-administer insulin.
3. 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.
4. 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, etc.) relative to the prescribed medication administration as the nurse determines necessary for my son's/daughter's health and safety.
5. I understand that I may personally retrieve the medication from the school at any time and that the medication will be destroyed if not picked up within seven (7) days following the termination of the physician's order or seven (7) days beyond the end of the current school year.
6. I have read, understand and agree to the SCHOOL'S MEDICATION POLICY IN THE STUDENT HANDBOOK.

Date: _____ Signature: _____ Relationship: _____