# School Nursing
# Life-Threatening Allergy EAP

*Medications may be administered at school by school personnel when necessary for school attendance. This completed form, along with the medication and/or special equipment items are to be brought to the school by the parent/guardian.*

**TO BE COMPLETED BY PARENT/GUARDIAN**

I, the parent/guardian of _____dob_____
request that the building administrator or his/her designee administer the medication or procedure listed below as directed. I give my consent for the exchange of information between the school and my child's health care provider. I give permission to share, if necessary, this information with school personnel who may be involved with the welfare of my child. I fully realize I can withdraw my request/consent in writing at any future date.

As a parent, I understand my responsibilities are:

1. To provide the school with a supply of medication in the original container appropriately labeled by the pharmacy. And/or any supplies needed to administer the medication.
2. To provide the school with the written doctor's instructions for medication administration during school hours. And that medication will not be administered until signed doctors instructions are at school.
3. To inform the school of any medical changes.
4. I will assume responsibility for safe delivery of the medication to school.
5. To provide the school with this signed consent form annually and when changes in medication occur.
6. I give permission for my child to self-administer rescue medication if approved by physician.
7. I release and agree to hold the Board of Education, its officials and its employees harmless from any and all liability foreseeable or unforeseeable for damage or injury resulting directly or indirectly from this authorization.
8. If your child is Medicaid eligible, school health services may bill on behalf of the school. School district billing will not impact future benefits of your family's Medicaid plan. This would include releasing Personally Identifiable Information (PII) about my child (including date of birth, disability, gender, school, date of services, type of services) to Michigan Medicaid and its billing agencies for Medicaid reimbursement of School-Based Services.

## Please complete attached life threatening allergy plan, or submit a current plan already on file in physician office.

Signature of
Parent/Guardian: _____ Relationship: _____ Date: _____

Emergency Contact Phone Number _____