



**PARENT / GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION
AND
MEDICATION ADMINISTRATION PLAN**

Student Name: _____ Date of Birth: _____ M / F (circle one)

School: _____ Grade: _____ Homeroom: _____

Parent/Guardian _____ / _____ / _____ / _____
(Print Name) (Cell #) (Home #) (Work #)

Parent/Guardian _____ / _____ / _____ / _____
(Print Name) (Cell #) (Home #) (Work #)

Emergency Contact _____ / _____ / _____ / _____
(Print Name) (Relationship to child) (Cell#) (Home #)

Child's known allergies: _____

My child is currently receiving the following medications at home:

1. _____ 2. _____ 3. _____ 4. _____

I give permission for the school nurse (or school personnel designated by school nurse) to give my child,
(Student Name) _____, the following medication(s):

Medication: _____ Prescribed by: _____

Medication: _____ Prescribed by: _____

Medication: _____ Prescribed by: _____

Medication: _____ Prescribed by: _____

____ Yes ____ No I give permission for the school nurse to share information, relative to prescribed medication, with appropriate school personnel as necessary for my child's safety and health (e.g. adverse side effects).

____ Yes ____ No I have reviewed the Medication Administration Plan (page 2) and I am in agreement with it.

____ Yes ____ No I understand that a picture of my child will be attached to the medical record in order to assure safe medication administration.

Parent/ Guardian Signature: _____ **Date:** _____

MEDICATION ADMINISTRATION PLAN

(Med Admin Plan Form required for each medication to be administered at school)

Student Name: _____ DOB: _____

Medication: _____

Possible Side Effects: _____

Special Directions: _____

Medication Storage: ☐ Locked in medication cabinet ☐ Refrigerator ☐ Unlocked drawer or cabinet

I give permission for my child to self-administer this medication if the school nurse determines it is safe and appropriate. ☐ YES ☐ NO

Scheduled Medication Plan for 2 hour early release: ☐ Give at school ☐ Do NOT give at school

(initial) I acknowledge that medication prescribed/ scheduled within one hour of the normal school start time **WILL NOT** be given at school on delayed opening (late start) days, per policy.

Quantity of medication received by school is recorded on the medication log. (No more than a 30 day supply may be kept at school.)

Medication will be administered in the Nurse's Office unless otherwise specified in special directions.

Medication may be administered by a responsible med delegated staff member in the absence of the school nurse.

Field Trip Plan: If a parent/ guardian does not attend the field trip with their child, student's medication will be delegated by the nurse to a trained, responsible faculty/ staff member who will be attending the field trip. The nurse will give the medication to this delegated person who will administer the medication to this student while on the field trip.

Not all medications can be delegated to school personnel. Please see your school nurse for clarification.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____