Medication Administration Plan
and Parent/Guardian Consent

Student's Name:_____Grade/Teacher: _____DOB: _____

Parent/Guardian Printed Names: _____

Address: _____

Home Phone: _____Work # _____Cell # _____

Other person to be notified in an emergency if the parent/guardian is unavailable:

Name: _____Phone # _____

Relationship: _____

Please list all medications your child is currently receiving, including those given during the school day (If not in violation of confidentiality): _____

_____

My son/daughter is known to have the following allergies: _____

I give permission for the school nurse (or appropriately trained school personnel, if epinephrine is required for an emergency) to give

_____ _____ _____

Medication Name to Student Name Prescribed By Licensed Prescriber

☐Yes ☐No

I give permission for my son/daughter to self-administer his/her ☐epinephrine and/or ☐inhaler and/or ☐insulin as prescribed by his/her physician. ☐Yes ☐No

I give permission for the school nurse to share information relevant to this medication as she determines necessary for my child's health and safety. ☐Yes ☐No

I have reviewed the following information with the school nurse:

Duration of order: _____Expiration date of medication received: _____

Possible side effects/adverse reaction: _____

Location/storage of medication: _____

Plan for field trips: _____

Plan for monitoring medication: _____

Medication may be retrieved from the school nurse at any time; however, the medication will be destroyed if it is not picked up within 1 week following the termination of the medication order or 1 day beyond the end of the school year.

Parent/guardian signature: _____Date: _____

School Nurse signature: _____Date: _____

Student signature (if applicable): _____Date: _____