**AVOYELLES PARISH SCHOOL BOARD**

PARENT/GUARDIAN WRITTEN CONSENT FOR MEDICATION ADMINISTRATION

SCHOOL YEAR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF STUDENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX:\_\_\_\_\_\_\_\_\_\_\_\_

SCHOOL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GRADE:\_\_\_\_\_\_\_\_\_\_\_\_\_ TEACHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME OF PARENT/GUARDIAN (please print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MAILING ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICAL (911) ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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TELEPHONE NUMBER (HOME) CELL NUMBER TELEPHONE NUMBER (WORK)

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Doctor’s Name Phone Number

**ALL MEDICATION STUDENT IS TAKING - INCLUDING MEDICATION GIVEN AT SCHOOL.**

**1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

ALLERGIES (FOOD/DRUGS):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OTHER ALLERGIES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **I give permission for school nurse to consult with my child’s physician and to share with school personnel information relative to medication administration as necessary for this school year.**
* **I give permission for school nurse to do health assessment on my child in school setting as required by State Law regarding administration of medicine.**
* **I give permission for my child’s picture to be taken which will be used to help identify student when he/ she comes for medicine (if school nurse feels it is necessary).**
* **I give permission for school nurse or trained unlicensed medicine designee to administer medicine to my child as prescribed by his/ her doctor.**
* **I have given the first dose of medicine ordered at home and have allowed at least twelve hours observing for possible adverse side effects of medicine.**
* **I understand that I am to remove unused, contaminated, discontinued, or out-of-date medicine from school, and that medicine will be destroyed according to policy guidelines if not picked up by the last day of school.**

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SIGNATURE OF PARENT DATE

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| **CONSENT FOR SELF-ADMINISTRATION OF MEDICATION:** I give permission for my child to self-administer medication provided doctor’s order includes the same, if the school nurse determines it is safe and appropriate.  I feel my child is sufficiently responsible and informed to administer his/her own medication.  I assume responsibility for my child’s actions in his/her self-management of medication.  SIGNATURE OF PARENT/GUARDIAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |