West Feliciana Parish School System
PARENT/GUARDIAN Consent for Medication in Schools

NAME OF STUDENT:_____ DOB_____

School:_____Grade:_____

Allergies:_____

List ALL current medications:_____

Parent/Guardian Name_____Phone_____

Emergency Contact Name_____Phone_____

Emergency Contact Name_____Phone_____

By signing this form I give permission for the school nurse or designated trained unlicensed school personnel to give the above listed child medications as listed below. I give permission for the school system to share with appropriate persons and agencies information relative to my child's diagnosis, treatment, and prescribed medication as the nurse determines necessary for my son's/daughter's health and safety. I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the end of the current school year. I have administered the initial dose ordered of each medication at home and have allowed sufficient time for observation of adverse reactions before asking school personnel to administer the medication. (Not applicable for emergency meds.) I understand that the medicine is to be brought to school by a responsible adult and properly labeled by a pharmacist. I assume all responsibility for any mistake in furnishing an incorrect dosage. I hereby release the West Feliciana Parish School System and its employees from all liability for injury or damage to the health of the child arising out of or resulting from the necessity of the child to take medication during school hours.

Medications to be administered:

_____ _____

_____ _____

_____ _____

Parent/Guardian Signature_____Date_____

This section is only for a student who will administer his/her own medication, such as asthma inhaler, diabetes medications, or auto-injectable epinephrine.

- Do you give permission for your son/daughter to self-administer medication if the school nurse determines it is safe and appropriate in the school setting? Yes_____ No_____
- Do you feel that your child is sufficiently responsible and informed to administer his/her own medication? Yes_____ No_____
- Do you assume responsibility for your child's actions in his/her self management of medication at school? Yes_____ No_____
- Do you understand that regular medication orders must be provided for students who self-administer medication at school? Yes_____ No_____

Parent/Guardian Signature_____Date_____