

Parent/Guardian Consent For Medication Administration

Student: _____ DOB: _____ Grade: _____

Parent/Guardian: _____ Address: _____

Phone: (H): _____ (W): _____ (C): _____

Emergency Contacts:

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

Medication student receives at home: _____

List all allergies: _____

Medication to be given at school: _____

Any special instructions for administration of medication: _____

Initial administration has been given at home and sufficient time has passed (24 hours) to observe for adverse reactions before asking school personnel to administer medication. Yes No

Do you give permission for the school nurse and in her absence unlicensed school personnel to administer this medication? Yes No

Use this box for the student who will administer his/her own medications, such as an asthma inhaler. The student will be required to notify the nurse in an event of self-administration. School Policy states that no child can carry medication on their person, book bag or lunchbox, etc. except for inhalers and other life-saving pharmaceuticals approved by the school nurse.

Do you give permission for your child to self-administer medication if the school nurse determines that is safe and appropriate? Yes No

Do you believe your child is sufficiently responsible and informed to administer his/her own medications? 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 medications at school? Yes No

I understand and agree that Runnels School and its employees are not responsible for any unintentional mistakes in keeping or giving my child's medication. I agree to hold Runnels School free and harmless of liability from injuries that might occur as a result of the administration of medications by school employees.

Date: _____

Signature: _____

(Physician to complete reverse side)

Runnels School Physician's Orders

(This request for medication administration at school must be completed by a licensed physician or dentist)

Student: _____ DOB: _____

Student Diagnosis (all): _____

Student general health status: _____

Medication to be given at school:

Medication	Dosage	Route	Time

Date to begin: _____ Date to end: _____

List contraindications or child-specific potential side effects to watch for at school:

Next office visit: _____

Use this section only for students who will administer their own medication such as students with an inhaler.

Has this student been adequately instructed by you or your staff and demonstrated competence in self-administration of this medication to the degree that he/she may self-administer his/her medication at school provided the school nurse has determined it is safe and appropriate for this particular student in this particular setting? Yes _____ No _____

Comments: _____

Date: _____ Signature: _____

Physician's Name (print): _____

Office Address: _____

Office Phone: _____

Office Fax: _____

(Parents to complete reverse side)