Parent/Guardian Consent for Administration of Medication and Medication Administration Plan

Student's Name:_____ DOB:_____
Address:_____ Grade:_____
Parent/Guardian Names: #1_____ #2_____
Home Phone No._____ #2_____
Cell Phone No._____ #2_____
Work Phone No._____ #2_____

Other person(s) to be notified in an emergency if the parent/guardian is unavailable:
Name(s): _____
Phone #_____ Relationship:_____

Name of licensed prescriber:_____ Phone number:_____

Please list all medications your child is currently receiving (if not in violation of confidentiality):

_____

My son/daughter has the following food or drug allergies. (Please specify past-reaction):

_____

Diagnosis (if not in violation of confidentiality):_____

I give permission for the school nurse/school personnel designated by the school nurse to administer the following medication:
Medication name:_____
Amount:_____ Route:_____ Time to be given:_____

I give permission for my son/daughter to self-administer the medication, if the school nurse determines it safe and appropriate.
Yes_____ No _____

I give permission for the school nurse to share information relevant to this medication as she determines necessary for my son's/daughter's health and safety.

I understand that the medication must be delivered to school health office by a responsible adult, in a properly labeled pharmacy container. Also, the medication must be accompanied by a medical provider medication order. I will supply a picture of my child. I understand that I may retrieve the medication from the school nurse at any time; however, the medication will be destroyed if it is not picked up within one week following the termination of the order or one day beyond the close of the school year.

The following is to be completed with the school nurse:
Duration of order:_____ to_____ Expiration date of medication received:_____
Possible side effects/adverse reaction:_____
Location/storage of medication:_____
Plan for field trips:_____ Delegated to:_____
Plan for monitoring medication:_____
Plan for teaching self administration with prescriber and parental consent:_____
_____ Date of self-medication observation:_____

Parent/Guardian signature:_____ Date:_____
School Nurse signature:_____ Date:_____
Student signature (if applicable:_____ Date:_____

Parent Consent for Acetaminophen, Ibuprofen, Antacid

Dear Parent/Guardian:

The Abington Public School health regulations allow the school nurse to administer acetaminophen, ibuprofen and antacid as needed to students with written parental permission (if acetaminophen, ibuprofen and antacid as needed to students with written parental permission (if student is under the age of eighteen). Students 18 years of age and older may sign the consent.

Please complete this form and check off the box to indicate that you grant permission for the school nurse to administer the medication.

Student's name:_____ DOB:_____

Address:_____ Grade:_____

Parent/Guardian names: #1_____ #2_____
Home Phone No._____ #2_____
Cell Phone No._____ #2_____
Work Phone No._____ #2_____

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

Name(s):_____
Phone#_____ Relationship:_____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality)

_____

My son/daughter has the following food or drug allergies:

_____

I consent to have the school nurse to administer the following medication.
(**Please check off only those medications you are giving consent for the nurse to administer**, this school year, if she deems it necessary upon her assessment.)

_____Acetaminophen _____Ibuprofen _____Antacid

I give permission for the school nurse to share information relevant to this medication as she determines necessary for my son's/daughter's health and safety. _____Yes _____No

Signature of parent/guardian:_____ Date:_____

Please be aware that if you plan to supply the medication for their personal use in school the medication must be delivered to the school nurse in the original manufacturer-labeled container by you or a responsible adult who you designate. Medication may be retrieved at any time; however the medication will be destroyed if it is not picked up within one day beyond the end of the school year.

Please do not hesitate to contact the school nurse if your child needs other medication to be administration during the school day or if you have questions.