FRANKLIN PARISH SCHOOLS

PARENT/GUARDIAN WRITTEN CONSENT FOR MEDICATION ADMINISTRATION

Name of student _____Sex:_____ Date of birth:_____

School:_____ Grade:_____

Name of Parent/Guardian:_____
please print

Mailing address:_____

Tel. #(Home):_____Tel.#(Work)_____Cell#_____

Other persons to be notified in case of emergency if parent/guardian is unavailable:

Name:_____Relationship:_____Tel.#_____

Name:_____Relationship:_____Tel.#_____

Please list all medication you child is receiving, including those given during the school day.
1._____2._____3._____

My child is known to have the following allergies:_____

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CONSENT

1. I hereby give my consent for the school nurse or the designated trained unlicensed school personnel to give the following medication_____prescribed by_____ to_____.

2. I give my permission for my child to self administer medication if the school nurse determines it is safe and appropriate in the school. Yes_____ No_____

3. I give permission for the school nurse to share with appropriate school personnel information relative my child's health condition and prescribed medication administration, e.g., adverse side effects, as she determines necessary for my child's health and safety. Yes_____ No_____
Restrictions on release_____

4. I understand that I may retrieve the medication from the school at anytime and that the medication will be destroyed if it is not picked up within 1 week following termination of the order or 1 week beyond the close of school.

Signature of Parent/Guardian_____