EBRP PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

(Please Print)

Student: ______________________________ Birthdate: _________________ Grade: __________

School: ________________________________ Teacher: ________________________________

Parent/Guardian: ____________________________ Address: ______________________________

Home Phone: _______________ Cell Phone: _______________ Business Phone: ______________

Other persons to be notified in case of emergency:

Name: ____________________________ Relationship: ________________ Phone: _____________

Name: ____________________________ Relationship: ________________ Phone: _____________

Medication to be given at school: ____

Special Instructions for giving your child this medication: _____________________________________

List all allergies: ____

List all medications student takes at home: ____

The following questions must be answered in order for your child to receive medications at school; all answers must be "Yes" before the medication can be administered at school by unlicensed trained personnel.

1. Have you received and reviewed the EBRP School Board Medication Policy? **Yes__ No__**
2. Do you give permission for the school nurse to share with designated trained unlicensed personnel information about your child relative to medication administration as the nurse deems necessary? **Yes__ No__**
3. Are there any restrictions on this release? ____
4. Do you understand that you may retrieve the medication from the school at any time and that the medication will be destroyed after you have been notified if it is not picked up within two weeks following the end of the term or when the medication orders are discontinued? **Yes__ No__**
5. Have you administered the initial dose at home and have you allowed sufficient time (overnight) for observation of adverse reactions before asking school personnel to administer the medication? **Yes__ No__**

Use this box ONLY for a student who will administer his/her own medication, such as asthma inhaler. The student will be required to record each dose.

1. Do you give permission for your child to self administers medication if the school nurse determines it is safe and appropriate in the school setting? **Yes__ No__**
2. Do you believe your child is sufficiently responsible and informed to administer his/her own medication? **Yes__ No__**
3. Do you assume responsibility for your child's actions in his/her self management of medication at school? **Yes__ No__**
4. Do you understand that regular medication orders must be provided by a physician for students who self administer medications at school? **Yes__ No__**

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

______________________________ ______________________

Parent/ Guardian Signature Date