# EBRPSS PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

Student: ______________________________ Birthdate: _______________ Grade: ___________

School: _______________________________ Teacher: ________________________________

Parent/Guardian: ___________________________ Address: _____________________________

Home/Phone: _________________ Cell: ___________________ Work: ______________________

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: _____________________________________

Does your child have any allergies? No □ Yes □ If yes, please list: ____________________________

List any/all medications your child takes at home: ____________________________________________

The questions below (1-5) must be answered in order for your child to receive medications at school:
***All answers must be "Yes" before medication can be administered by trained unlicensed 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□**

**For a student who will administer their own medication at school** (such as asthma inhaler).
*The student will be required to record each dose taken at school (record kept on file in school nurse's office)*

- 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**
- Do you believe 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 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 and its trained employees free and harmless from liability for any injuries which might result from the administration of medication to my child.

______________________________ ____________________

Parent/ Guardian Signature Date