EBRP Parent/Guardian Consent for Medication Administration

(Please Print)
Student: _____ DOB: _____ Grade: _____
School: _____ Teacher: _____
Parent/Guardian: _____ Address: _____
Home Phone: _____ Business Phone: _____
Other persons to be notified in case of emergency:
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Medication: _____ Prescription #: _____
List any allergies: _____
Are there any special instructions for giving your child this medication? _____
_____
List medications student receives at home: _____

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____ Are there any restrictions on this release? _____

3. 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 ____

4. 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 ____

All above answers must be "Yes" before the medication can be administered at school by unlicensed trained personnel.

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

Do you give permission for your child to self administer 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 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.

X _____
Date Parent/Guardian's Signature