



**Health Services Department**  
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**STUDENT  
PICTURE  
HERE**

## PARENTAL CONSENT TO STUDENT MEDICATION PLAN

--Valid Only for One Year --

NAME OF STUDENT: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_ TEACHER: \_\_\_\_\_

I hereby freely request, agree with, and consent to the following (CHECK ONLY ONE BOX BELOW)

☐ **School Assistance in the Administration of Medication**

1. A school site administrator or school nurse may communicate directly with my child's health care provider and pharmacist regarding the administration of medication to my child at school and I will sign a release to allow this
2. I will provide the necessary medication, supplies and equipment to the school site in a separate pharmaceutical-labeled container(s)
3. I will notify immediately the school site administrator or school nurse if there is a change in my child's medication, health status, or healthcare provider and provide new written consent along with updated authorization from my child's healthcare provider
4. I understand that no changes to this Plan will be made unless and until the school site administrator or school nurse receives those changes in writing from my child's health care provider
5. I understand that in order to withdraw my consent to this Plan, I must do so in a written statement to the school site administrator or school nurse

☐ **Self-Administration of Medication (ONLY for auto-injectable epinephrine, inhaled asthma medication, or diabetes-related self-care)**

1. I release the school district and school personnel from civil liability if my child suffers an adverse reaction as a result of self-administering medication
2. My child is capable of possessing and using the medication and related equipment and supplies by him/herself
3. My child is capable of adhering to standard precautions and appropriate handling of syringes, needles, lancets, and other medical equipment
4. My child is capable of maintaining his or her own safety and that of others in his or her use of the medication and related equipment and supplies
5. My child is capable of maintaining his or her own privacy in his or her use of the medication and related equipment and supplies
6. My child fully understands the terms of the written agreement pertaining to his or her self-administration of medication at school.
7. My child understands he or she shall not administer the medication to any other child

Parent/Guardian (Signature) \_\_\_\_\_

Address: \_\_\_\_\_

Parent/Guardian (Printed Name) \_\_\_\_\_

Phone: \_\_\_\_\_

Date \_\_\_\_\_

Other Phone: \_\_\_\_\_

### TO BE COMPLETED BY HEALTH CARE PROVIDER

Name of Medication (as prescribed) \_\_\_\_\_ Dosage \_\_\_\_\_ Method of Administration \_\_\_\_\_

Time (s) to be administered at school \_\_\_\_\_ Duration \_\_\_\_\_

Health condition for medication \_\_\_\_\_

Special instructions/precautions \_\_\_\_\_

Possible side effects \_\_\_\_\_

I AGREE with the parent/guardian's assessment that this child is competent to safely self-administer his/her medication (as set forth above) and it is my professional opinion that this child may be allowed to carry and use the medication at school by him/herself. Yes \_\_\_ No \_\_\_

HealthCare Provider's Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax/Email: \_\_\_\_\_

School Nurse: It is my professional opinion that (print name of student) \_\_\_\_\_ is competent to safely carry and use his/her medication by him/herself. YES \_\_\_ NO \_\_\_

School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_