

St. Tammany Parish School Board School Nurse Program

COVINGTON ANNEX 898-3375 * FAX 898-3377
COVINGTON HIGH SCHOOL 892-3799 * FAX 892-3799
HARRISON CURRICULUM CENTER 898-3311 * FAX 898-3324
SLIDELL CURRICULUM CENTER 646-4912 * FAX 646-4938

PARENTAL REQUEST FOR ADMINISTERING MEDICATION AT SCHOOL AND RELEASE FROM LIABILITY
NAME OF STUDENT: _____ D.O.B.: _____
SCHOOL: _____ GRADE: _____ TEACHER: _____
NAME OF PARENT/GUARDIAN: _____ HOME PHONE: _____
WORK NUMBER: _____ CELL NUMBER: _____

1. I hereby give permission for the school nurse or the designated unlicensed person, trained to administer medication at school, to give the following medication ordered by the physician. YES ___ NO ___
2. I have administered the initial dose ordered at home and have allowed sufficient time for observation of adverse reactions before asking school personnel to administer the medication. YES ___ NO ___
3. My child has permission to carry and self-administer his/her inhaler/emergency medication if ordered by the prescriber and in concurrence with the school nurse assessment. YES ___ NO ___
4. Do you assume responsibility for your child's actions in his/her self-management of medication at school? YES ___ NO ___

Medication must be brought to school and retrieved by a responsible adult. Medication will be destroyed if it is not picked up within two weeks following termination of the order or two weeks beyond the end of the current school year.

Printed Name of Parent/Guardian _____ Signature of Parent/Guardian _____ DATE: _____

PHYSICIAN, DENTIST OR OTHER AUTHORIZED PRESCRIBER: LOUISIANA OR ADJACENT STATE
In most instances, the medication will be administered by unlicensed, trained, school personnel. Please make the following orders clear enough for them to understand.
DIAGNOSIS: _____

DESIRED EFFECT: _____

MEDICATION: _____ **DOSAGE:** _____

DISCONTINUE DATE: _____ **AT STUDENT'S LUNCH TIME:** YES ___ NO ___
IF NOT, SPECIFY TIME: _____

Possible Side Effects/Contraindications/Adverse Reactions: _____
Please list other medications being taken by this student outside of school: _____
STUDENT ALLERGIES: _____

NOTICE: USE THIS SECTION ONLY FOR A STUDENT WHO WILL SELF-ADMINISTER HIS/HER OWN MEDICATION, SUCH AS AN ASTHMA INHALER OR OTHER EMERGENCY MEDICATION.
Has this student been adequately instructed by you or your staff and demonstrated competence in self-administration of medication to the degree that he/she may self-administer his/her medication at school provided the school nurse has determined it is safe and appropriate for this student in the particular school setting? YES ___ NO ___
Do you give authorization for this student to carry his/her own medication, if it is requested by the parent and the school nurse has determined it safe and appropriate? YES ___ NO ___

PHYSICIAN'S NAME (PLEASE PRINT): _____ **DATE:** _____
PHYSICIAN'S SIGNATURE: _____ **PHONE:** _____
ADDRESS: _____