THE GREATER ALLEGHANY SCHOOL HEALTH PROJECT

Parental/Physician Consent for Administering Medication
(Use a separate authorization for each medication)

PARENTAL CONSENT

Student Name _____ Birthdate _____

Allergies _____ Grade _____

I am the parent/guardian of _____. I give my permission for him/her to take the following prescribed medication while in _____ School. I hereby acknowledge that I have read and understood the School Board Regulations relating to medication use. I hereby release my child's school and its employees from any claims or liability connected with its reliance on this permission and agree to indemnify, defend, and hold them harmless from any claim or liability connected with such reliance. I authorize a representative of the school to share information regarding this medication with the prescriber listed below. I authorize trained employees to administer insulin or glucagon to my diabetic child in the absence of a registered nurse, nurse practitioner, physician, or physician assistant.

This medication has been given at least once prior to requesting administration at school.

_____ _____ _____
Parent/Guardian Signature Daytime Phone Date

MEDICATION AUTHORIZATION (To be completed by Physician/Licensed Prescriber ONLY)

Relevant Diagnosis _____ Name of Medication _____

Dates medication must be administered at school: (check one)
_____ Short Term _____ Episodic/Emergency Events Only
_____ Every Day At School _____ PRN

Dosage (Amount) _____ Route _____ Form _____ Time(s) of day _____

A) Can serious reactions occur if this medication is not given as prescribed? YES ____ NO ____ (If yes, please describe):

B) Serious reactions/adverse side effects from this medication may occur? YES ____ NO ____ (If yes, please describe):

ACTION/TREATMENT for reaction:
_____
Report to you? YES ___ NO ___

Special Handling Instruction: Refrigeration ___ Keep out of sunlight ___ Other _____

Asthmatics/Diabetics ONLY: Is this student responsible for self-administering this medication?
YES (supervised) ___ YES (unsupervised) ___ NO ___ This student may carry this medication? YES ___ NO ___

Diabetics ONLY: Trained employees may administer insulin or glucagon in the absence of a registered nurse, nurse practitioner, physician, or physician assistant? YES ___ NO ___

Physician/Licensed Prescriber Name _____ Phone Number _____

Physician/Licensed Prescriber Signature _____ Date _____