

**CADDO PARISH SCHOOL BOARD**

P. O. Box 32000; 1961 Midway Street

Shreveport, Louisiana 71130-2000

**(THIS SIDE TO BE COMPLETED BY PARENT OR GUARDIAN)**

NAME OF STUDENT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_

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

NAME OF PARENT/GUARDIAN \_\_\_\_\_ PHONE(hm) \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE(wk) \_\_\_\_\_

Other persons to be notified in case of emergency if parent/guardian is unavailable:

NAME \_\_\_\_\_ Relationship \_\_\_\_\_ Phone(hm) \_\_\_\_\_ Phone(wk) \_\_\_\_\_

STUDENT ALLERGIES:(List medication, food, etc. student is allergic to) \_\_\_\_\_

**PARENT/GUARDIAN'S CONSENT**

1. I hereby give permission for the school nurse or the designated unlicensed person, trained to administer medication at school, to give the following:

\_\_\_\_\_ to \_\_\_\_\_ prescribed by: \_\_\_\_\_  
(Name of Medication) (Name of Student) (Name of Doctor or Dentist)

2. Yes \_\_\_ I give permission to the school nurse to share with appropriate school personnel, physicians or medical facility, information relative to the prescribed medication administration as the nurse determines necessary for my son's/daughter's health safety.

3. Yes \_\_\_ I understand I may retrieve the medication from the school at anytime and that the 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 term.

4. I have administered the initial dose of ordered medicine at home and have allowed twelve (12) hours for observation of adverse reactions before asking school personnel to administer the medication. Yes \_\_\_ No \_\_\_

NOTE: All answers above must be "YES" before unlicensed personnel may administer the medication at school, unless other arrangements have been agreed on by parents and nurse.

**5. SPECIFIC EMERGENCIES:**

IF YOU SEE THIS	DO THIS

I am aware that if my child has an emergency in school and I am not available, the school principal or alternate will have my child transported to the emergency room. I will be responsible for payment of emergency care.

Hospital of choice \_\_\_\_\_ Physician \_\_\_\_\_

**NOTICE: USE THIS BOX ONLY FOR A STUDENT WHO WILL ADMINISTER HIS/HER OWN MEDICATION: SUCH AS AN ASTHMA INHALER. STUDENT WILL BE REQUIRED TO RECORD EACH DOSE.**

Do you give permission for your son/daughter to self-administer medication if the school nurse determines it is safe and appropriate in the school setting?  YES  NO

Do you feel that 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 medication at school?  YES  NO

**SIGNATURE OF PARENT/GUARDIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_

Relationship to Student \_\_\_\_\_ RX Number \_\_\_\_\_