Lycee Francais de la Nouvelle-Orleans

PARENT/GUARDIAN WRITTEN REQUEST AND CONSENT FOR MEDICATION ADMINISTRATION

General Information

Name of Student:_________________________________School:___________________Grade:____

Date of Birth:_______________Sex:________
Name of Parent/Guardian:____
Please Print
Phone: Home____________________Work:________________________Cell:_____________________

Other Persons to be notified in case of emergency if parent/guardian is unavailable:
Name:______________________________Phone:_____________________Relationship:____________

My son/daughter is currently receiving the following medications: Please list all medicines the child is receiving at home or at school.
1.__________________________2.____________________________
3.________________________4.__________________________5.____________________________

My son/daughter is known to have the following allergies:_____________________________________

Consent

1. I hereby give permission for the school nurse or the designated unlicensed school personnel to give the following medicine:_______________________________________prescribed by
Name of Medication
__________________________________ to _______________________________________.
Licensed Prescriber Name of Student

2. I give permission for my son/daughter to self-administer medication if the school nurse determines it is safe and appropriate in the school. Yes______No_______

3. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medicine administration (e.g. desired effect, adverse side effects) as she/he determines necessary for my son/daughter's health and safety.
Yes____No_____
Restrictions on release, if any:____

Please note: I understand that I may retrieve the medicine from the school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the prescriber's order or 2 weeks beyond the close of school.

Signature of Parent/Guardian:____

Relationship to Student:___________________________________Date:__________________________

School Nurse Signature:____Date:_______________________