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	646-4914	* 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 concurance 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 by 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.

_____ _____ DATE: _____

Printed Name of Parent/Guardian Signature of Parent/Guardian

PHYSICIAN, DENTIST OR OTHER AUTHORIZED PRESCRIBER: LOUISIANA OR ADJACENT STATE

In most instances, the medication will be adminstered 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): _____

PHYSICIAN'S SIGNATURE:_____ DATE: _____

ADDRESS: _____ PHONE: _____