EVANGELINE PARSH SCHOOL BOARD
(THIS SIDE TO BE COMPLETED BY PARENT OR GUARDIAN)

GENERAL INFORMATION

NAME OF STUDENT: _____ DATE OF BIRTH: _____ SEX:____
SCHOOL: _____ GRADE: _____ TEACHER: _____
NAME OF PARENT/GUARDIAN: _____
ADDRESS: _____PHONE:_____
Other Persons to be notified in case of an emergency if parent/guardian is unavailable:
NAME: _____ RELATIONSHIP: _____
PHONE: (HM) _____ (WK) _____
STUDENT ALLERGIES: (List medication, food, etc.) _____

PARENT/GUARDIAN CONSENT

1. I hereby give permission to the school nurse or the designated school employee to give _____ _____ to _____ at
   Name of medication **Dosage** **Name of student**
   school at _____ & _____ as prescribed by _____.
   Time **Time** **Name of Licensed Prescriber**
2. I give permission to the school nurse to share with appropriate personnel information (such as adverse/ side effects) relative to the prescribed medication administration as the nurse determines necessary for my son's/daughter's health and safety. **YES _____ NO _____**
3. I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within **one** week following termination of the order or **one** week beyond the end of the current school term. **YES _____ NO _____**
4. I have administered the initial dose ordered at home and have allowed **two hours** for observation of adverse reactions before asking school personnel to administer the medication. **YES _____ NO _____**
5. I understand that emergency medications are not routinely administered on school buses. Emergency medications include but are not limited to diastat, glucagon, epipen, asthma medications, etc. I also understand that my child may have a medical emergency while being transported on a school bus without his/her medications being available. However, with this understanding, I request that my child ride the school bus and if a medical emergency should occur that the bus driver pull over and call 911. **YES _____ NO_____**

NOTE: ALL ANSWERS ABOVE MUST BE "YES" BEFORE THE MEDICATION MAY BE CONSIDERED FOR ADMINISTRATION AT SCHOOL BY UNLICENSED PERSONNEL, UNLESS OTHER ARRANGEMENTS HAVE BEEN AGREED UPON BY PARENTS AND NURSE.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

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

Do you give permission for your son/daughter to self-administer medication if a doctor and nurse determine it is safe and appropriate in the school setting? **YES _____ NO _____**
Do you feel that your child is sufficiently responsible and has been properly trained to administer his/her own medication?
YES _____ NO _____

I will not hold the school and its employees responsible for any injuries sustained by this student from the self-administration of this medication which has been prescribed to treat asthma or anaphylaxis. I understand that the school shall incur no liability and that I shall indemnify and hold harmless the school and its employees against any claims that may arise relating to the self-administration of medications used to treat asthma or anaphylaxis.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____