

CANTON PUBLIC SCHOOLS HEALTH SERVICES

MEDICATION ADMINISTRATION PLAN and PARENT/GUARDIAN CONSENT

Student's Name: _____ Grade/Teacher: _____ DOB: _____

Parent/Guardian Printed Names: _____

Address: _____

Phone: Home: _____ Work _____ Cell _____

Other person to be notified in an emergency if the parent/guardian is unavailable:

Name: _____ Phone _____

Relationship: _____

Please list all medications your child is currently receiving, including those given during the school day (If not in violation of confidentiality): _____

My son/daughter is known to have the following food or drug allergies: _____

I give permission for the school nurse (or appropriately trained school personnel, if epinephrine is required for an emergency) to give _____ (medication name) to _____ (student name) prescribed by _____ (licensed prescriber). Yes _____ No _____

I give permission for my son/daughter to self administer his/her epinephrine _____ and/or inhaler _____ as prescribed by his/her physician. Yes _____ No _____

I give permission for the school nurse to share information relevant to this medication as she determines necessary for my child's health and safety. Yes _____ No _____

I have reviewed the following information with the school nurse:

Duration of order: _____ Expiration date of medication received: _____

Possible side effects/adverse reaction: _____

Location/storage of medication: Medication Cabinet in Health Office

Location of Medication Administration: School Health Office

Should medication be given on early release days? Yes _____ No _____

Plan for field trips: Not needed on field trip _____ Parent/Guardian will chaperone: _____

RN coverage needed _____ Other _____

Plans for teaching self administration, if applicable _____

Plan for monitoring medication: Student to return to nurse if needed

I understand that the medication must be delivered by a responsible adult, in a properly labeled pharmacy bottle to the health office. The medication must be accompanied by a Medical Provider Permission Slip. Unused medication must be picked up within one week of the termination of the physician's order or within one week after school ends or it will be discarded.

Parent/guardian signature: _____ Date: _____

School Nurse signature: _____ Date: _____

Student signature (if applicable): _____ Date: _____