

Hadley Public Schools  
Parent/Guardian Consent for Medication Administration

File: JLCD-E-1

Name of student \_\_\_\_\_ DOB \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

street town zip

Telephone #'s \_\_\_\_\_

home work cell

Allergies to \_\_\_\_\_ food \_\_\_\_\_ medicine \_\_\_\_\_ other \_\_\_\_\_

**Medication #1**

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Route \_\_\_\_\_ Time \_\_\_\_\_

**Medication #2**

Name \_\_\_\_\_ Dosage \_\_\_\_\_ Route \_\_\_\_\_ Time \_\_\_\_\_

1. Is supervised self-administration of medication approved, provided the school nurse determines it is safe and appropriate in the school setting and the physician agrees? (The student is monitored by staff while taking the medication, does not have access to other student's medications and the medication is stored in a locked cabinet at all times.)

Yes \_\_\_\_ No \_\_\_\_

2. If this student utilizes a rescue inhaler for asthma, and the school nurse determines that it is appropriate and safe, may they carry and self-administer on school field trips, school sponsored activities, and during school athletics?

Yes \_\_\_\_ No \_\_\_\_

3. If this student utilizes a rescue inhaler for asthma, and the school nurse determines that it is appropriate and safe, may they carry and self-administer on a school field trip and during school athletics?

Yes \_\_\_\_ No \_\_\_\_

4. If this student utilizes an Epi-Pen for an anaphylactic reaction, and the school nurse determines that it is appropriate and safe, may they carry and self-administer on school field trips, school sponsored events, and during school athletics?

Yes \_\_\_\_ No \_\_\_\_

5. I give permission for the school nurse or nurse leader to delegate the administration of this (these) medication(s) to another staff member who has been trained in medication administration procedure.

Yes \_\_\_\_ No \_\_\_\_

6. I give permission for the school nurse to share with appropriate school personnel information relative to the administration of prescribed medication, ie. adverse side effects, as she/he deems necessary for my child's health and safety.

Yes \_\_\_\_ No \_\_\_\_

As a parent I agree to respond promptly when notified by the school nurse that my child's medication supply is getting low or if a medication (such as an inhaler or Epi-Pen) has an imminent expiration date.

Please note that medications may be picked up at any time by a parent/guardian during school hours. Medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date