

**PARENT/LEGAL GUARDIAN'S REQUEST AND AUTHORIZATION FOR MEDICATION
IN LOUISIANA PUBLIC SCHOOL SYSTEMS
(Please Print)**

STUDENT: _____ DOB: _____ GRADE: _____

ADDRESS: _____ TEACHER: _____

PARENT/LEGAL GUARDIAN NAME: _____ SCHOOL: Ben Franklin High

PHONE: HOME: _____ BUSINESS: _____

OTHER PERSONS TO BE NOTIFIED IN CASE OF EMERGENCY:

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

NAME OF MEDICATION: _____

LIST KNOWN ALLERGIES: _____

LIST MEDICATIONS STUDENT RECEIVES AT HOME: _____

Do you give permission for the school nurse to share with designated trained unlicensed personnel information about your child relative to medication administration as the nurse deems necessary?

YES: _____

Any restrictions on this release? _____

Do you understand that this medication will be destroyed if not picked up at the end of the school year or when the medication orders are discontinued?

YES: _____

Have you administered the initial dose at home and have you allowed sufficient time (overnight) for observation of adverse reactions before asking school personnel to administer the medication?

YES: _____

Do you agree to have your child's medication dosage withheld while on a field trip?

YES: _____

NO: _____ (Medication can **not** be withheld for life-threatening conditions)

I have read the two page document, "Role of the Parent/Legal Guardian In The Administration of Medication At School" and I agree to fulfill all the 16 responsibilities listed there in.

YES: _____

Date

Parent/Legal Guardian's Signature