



BAYOU COMMUNITY ACADEMY  
800 EAST 7<sup>TH</sup> STREET

THIBODAUX, LOUISIANA 70301

### Medication Permission Form for Parent/Guardian

STUDENT NAME \_\_\_\_\_ DOB \_\_\_\_\_ SEX \_\_\_\_\_ H/R \_\_\_\_\_ GRADE \_\_\_\_\_

PARENT/GUARDIAN NAME \_\_\_\_\_ PHONE: \_\_\_\_\_ Alt Ph: \_\_\_\_\_

Other persons to be notified in case of emergency if parent/guardian is unavailable:

Name: \_\_\_\_\_ Ph: \_\_\_\_\_ Alt Ph: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Name: \_\_\_\_\_ Ph: \_\_\_\_\_ Alt Ph: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

STUDENT ALLERGIES: (Medications, food, etc.) \_\_\_\_\_

Parent/Guardian's Consent (*Parents must initial each blank at the beginning of each statement.*)

\_\_\_\_\_ I hereby give permission for the school nurse or the designated unlicensed person, trained to administer medication at school, to give the following \_\_\_\_\_ (Medication) to \_\_\_\_\_ (Student's Name) prescribed by \_\_\_\_\_ (Doctor's Name).

\_\_\_\_\_ I give permission to the school nurse to share with authorized prescriber and appropriate school 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 and also to consult with the prescriber.

Restrictions on release: \_\_\_\_\_.

\_\_\_\_\_ I give permission, in an emergency, for the nurse on campus to provide my sons/daughters medical information to school administrators and all persons providing emergency medical care.

\_\_\_\_\_ 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 two weeks following termination of the order or two weeks beyond the end of the current school term.

\_\_\_\_\_ 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.

\_\_\_\_\_ I give permission to withhold this medication on field trips or activities held outside of the scheduled school day.

**NOTICE: USE THIS BOX ONLY FOR A STUDENT WHO WILL ADMINISTER HIS/HER OWN ASTHMA INHALER, INSULIN, OR EMERGENCY INJECTABLES FOR ALLERGIC REACTIONS**

1. Do you give permission for your son/daughter to self-administer medication if the school nurse determines if it is safe and appropriate in the school setting? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Do you feel that your child is sufficiently responsible and informed to administer his/her own medication? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Do you assume responsibility for your child's actions in his/her self-management of medication at school? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Do you understand that regular medication orders must be provided for students who self-administer medication at school? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Do you understand that self-administration will be considered on a case by case basis that is consistent with the Lafourche Parish School Board & BCA policy? Yes \_\_\_\_\_ No \_\_\_\_\_

By signing below, I acknowledge that I understand that pursuant to La. R.S. 17:436.1(J)(3), the Lafourche Parish School Board, Bayou Community Academy and its employees shall incur no liability as a result of any injury sustained by the student from the self-administration of medications used to treat asthma or anaphylaxis.

**Emergency Plan: I am aware that if my child has an emergency in school, the principal or alternate will have my child transported to the hospital emergency room by ambulance. I will be responsible for payment.**

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

RELATIONSHIP TO STUDENT: \_\_\_\_\_