GILLINGHAM
CHARTER SCHOOL
A Charlotte Mason Public Education

MEDICATION CONSENT FORM

Student Name ____ **Grade** ______ **School Year** ________________

In order to help protect your child's health, <u>your consent and written authorization from a health care provider</u> with prescriptive authority is required when it is necessary for your child to receive prescription and/or non-prescription medicines.

Parent/Guardian Permission: I give permission for my child to receive this medicine during school hours. Arrangements for administration of medication essential to your child's health while on field study is the parent's responsibility, please notify the nurse anytime your child attends a field study. I also give permission for school nurse to contact the prescribing healthcare provider with questions/concerns. I understand that it is my responsibility to purchase and supply this medicine in its original container. On behalf of my child I absolve the Gillingham Charter School and employees from any and all liability whatsoever that may result from my child taking this medicine.

____ ____ ___________________

Parent/Guardian Printed Name   Parent/Guardian Signature   Date

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Medical Diagnosis: ____

1. Medication/ Strength ___________________________________Directions____
2. Medication/ Strength ___________________________________Directions____
3. Medication/ Strength ___________________________________Directions____

☐ Check if any above medication is to be used for emergencies/self-carry.

*******Both sides of this form are required for emergency self-carry medications*******

Specific Directions (include at what time, relationship to meals, specific indications if "as needed"):

____

____

____

Expected side effects or adverse reactions:____

Specific indication____

Other information: ____

Healthcare Provider Permission: It is necessary for this student to receive this medication during school hours in order to maintain or improve health and to benefit from school attendance. Please notify the school nurse or principal if there are any problems or change to medication order.

____ ____ ___________________

Signature of Healthcare Provider   Print practitioner's last name   Date

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Practice name	Practice Address	Practice Phone

AUTHORIZATION FOR SELF-CARRY EMERGENCY MEDICATIONS

*Eligibility: Students with asthma, diabetes and/or severe allergies who may require rescue medications

Student Name _____ **Grade** _____ **Birth Date** _____

I agree that the above named student is responsible and capable of self-administration of the following medications. (Please check all that apply) :

- ☐ Rapid-Acting bronchial inhaler (please include medication name, dose and frequency)
  _____
- ☐ Auto- Injectable Epinephrine (please include medication name, dose and frequency)
  _____
- ☐ Gulcagon Injection (please include medication name, dose and frequency)
  _____

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Healthcare Provider Permission: This student is capable of and has been instructed on how to self-carry and, if applicable, administer this medication as directed on the medication consent form (both correct technique and dose intervals). Please allow him/her to self-carry it during school hours or activities.

Signature of Healthcare Provider	Print practitioner's last name	Date

Parent/Guardian Permission: I give consent to the Gillingham Charter School to allow my child to self-carry and, when applicable, to self-administer this medicine at school. I understand that my child and I assume responsibility for the proper use and safekeeping of this medicine. I will provide backup medication to be kept at school. I absolve the Gillingham Charter School and their agents and employees from any and all liability whatsoever that may result from my child carrying this medicine at school.

Parent/Guardian Printed Name	Parent/Guardian Signature	Date

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Student: I am capable of carrying this medicine as recommended and accept this responsibility. I will keep it secure at all times and will not share it with others. I understand that I will be subject to disciplinary actions if medications are shared. I will inform an adult when medication is used.

Student Printed Name	Student Signature	Date