

New Orleans Campus  
8400 Hayne Blvd.  
New Orleans, LA 70127  
(504) 242-6270

Slidell Campus  
363 Thompson Road  
Slidell, Louisiana 70460  
(985) 641-3363

Madisonville Campus  
235 Hwy. 21  
Madisonville, LA 70447  
(985) 845-3537

**Request for Administering Medication at School and  
Release from Liability**

*This form MUST be completed by parent and, where indicated, physician before ANY medication is administered.*

DATE: \_\_\_\_\_

Name of Student: \_\_\_\_\_  
LAST FIRST MIDDLE NICKNAME

Student Date of Birth: \_\_\_\_\_ Sex: M F  
(CIRCLE ONE)

Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

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

Telephone Numbers: Home \_\_\_\_\_  
(INCLUDE AREA CODES)

Work \_\_\_\_\_ Cell \_\_\_\_\_

Student Allergies: (list medication, food, etc. to which student is allergic) \_\_\_\_\_

I, \_\_\_\_\_, hereby give permission for the  
PARENT'S NAME (PRINT)  
school administration/teacher, or other unlicensed person to give the following medication to my  
child (describe in detail):  
\_\_\_\_\_  
\_\_\_\_\_

Prescribed by: \_\_\_\_\_  
PHYSICIAN'S NAME

I give permission to the school administration to share with appropriate school personnel  
information (such as adverse side effects) relative to the prescribed medication administration as  
the administrator determines necessary for my child's health and safety. I have administered the  
initial dose at home and have allowed sufficient time for observation of adverse reactions before  
asking school personnel to administer the medication.

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN DATE: \_\_\_\_\_

**TO BE COMPLETED BY A LICENSED PHYSICIAN OR DENTIST**

**STUDENT:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

NAME OF LICENSED PRESCRIBER: \_\_\_\_\_

OFFICE PHONE: (\_\_\_\_) \_\_\_\_\_ EMERGENCY: (\_\_\_\_) \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_

MEDICATION \_\_\_\_\_ Desired Effects: \_\_\_\_\_

DOSAGE \_\_\_\_\_ FREQUENCY \_\_\_\_\_

Specific Directions or Information for Administration: \_\_\_\_\_

Date of Order: \_\_\_\_\_ Discontinuation Date: \_\_\_\_\_

Contraindications to this Medication or Specific Effects to this Student: \_\_\_\_\_

Please list other medications taken by this student outside of school: \_\_\_\_\_

If student will self-administer his/her own medication, such as an asthma inhaler or other emergency medication, has this student been adequately instructed by you or your staff and demonstrated competence in self-administration of medication to the degree that he/she may self-administer his/her medication at school?

YES \_\_\_\_\_ NO \_\_\_\_\_

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**PARENTAL CONSENT FOR STUDENTS WHO WILL SELF-ADMINISTER HIS/HER OWN MEDICATION, SUCH AS ASTHMA INHALER, INSULIN, OR OTHER EMERGENCY MEDICATION**

Do you give permission for your child to self-administer medication? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you feel that your child is sufficiently responsible and informed to administer his/her own medication? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you assume responsibility for your child's actions in his/her self-management of medication at school? YES \_\_\_\_\_ NO \_\_\_\_\_

Do you understand that regular medication orders must be provided for students who self-administer medication at school? YES \_\_\_\_\_ NO \_\_\_\_\_

\_\_\_\_\_  
PARENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_