**Benjamin Banneker Charter Public School**
School Health Office

# Emergency Medical / Consent Form

In order for medication (prescription and non-prescription) to be given to your child during school, this form needs to be completed by both you and your child's doctor or clinic. Return the completed form to your child's school nurse.

**Name of Child**_____ **Date of Birth**_____ **Grade**_____

**RACE:** __Black/African American __Hispanic/ Latino __American Indian __Pacific Islander __Asian __White

## MEDICAL PROVIDER INFORMATION

**Provider's name**_____ **Clinic/Practice name** _____
**Tel.**_____ **Fax**_____ **Email.** _____
Diagnosis_____
Medication_____
Route of administration_____ Dosage_____
Frequency_____ Time(s) of administration_____
Date of order_____ Discontinuation date_____
Specific directions or information for medication_____ _____ _____
Any other medical condition(s)_____
**Allergies**_____

**Please attach a Doctor's note with all medications**
If your child is prescribed a medicine to be taken during school hours a note must be attached to this form

## PARENT/GUARDIAN INFORMATION AND CONSENT

Parent/Guardian Name_____
Tel # (H)_____
(C)_____
(W)_____
Email_____

Parent/Guardian Name_____
Tel # (H)_____
(C)_____
(W)_____
Email_____

Other person(s) to be notified in case of medication emergency:
Name:_____ Relationship:_____ Telephone #:_____
Name:_____ Relationship:_____ Telephone #:_____

| **Please complete each item and initial.** | |
|---|---|
| I give permission to have the school nurse or school personnel designated by the school nurse administer this medication. (this includes tylenol) | ____Yes ____No (Please Initial) |
| I give permission to the school nurse to share information relevant to the prescribed medication administration as s/he determines appropriate for my child's health and safety. | ____Yes ____No (Please Initial) |
| I give permission to the school nurse to photograph my child, to keep on file for identification purposes only. | ____Yes ____No (Please Initial) |
| I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or by the last day of the school. | ____Yes ____No (Please Initial) |

_____ _____ _____
**Parent/Guardian Signature** Please Print Name Here Date

**For Clinical / Office Use Only**

_____ _____ _____
**Nurse Signature** Please Print Name Here Date