PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

Student's Name____

Date of Birth ______________________________ Grade ____________________

Name(s) of Parent/Guardian(s) ____
Please Print

Address____

Telephone/Home _____________________Parent/Work ______________________

Cell________________ Cell___________________

Other person, if any, to be notified in case of emergency if parent(s)/guardian(s) is/are unavailable:

Name ___________________________________ Relationship _________________

Telephone _________________________________

My child is currently receiving the following medication(s) – To be completed if not in violation of confidentiality ____

My child has the following food, drug/insect allergies ____________________________

I consent to have the school nurse, or school personnel designated by the school nurse, give the following medication(s) __________________________________ to my child.

I give permission for my son/daughter to self-carry and self-administer medication if the school nurse determines it is safe and appropriate. Yes __________ No __________

I give permission to the school nurse to share information relevant to the prescribed medicine administration, e.g., adverse side effects, as she/he determines necessary for my son's/daughter's health and safety. Yes __________ No __________

I understand I may retrieve the medication from 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 one week beyond the close of school.

Medication needed outside the parameters of a regular school day will be provided by the parent/guardian (i.e. field trips, band trips, sports events, after school programs).

Signature ____ Date __________

Relationship to Student ____