WRITTEN PARENT/GUARDIAN CONSENT
FOR PRESCRIPTION MEDICATION ADMINISTRATION

General Information

Name of Student____________________________School_______________Grade_______
Date of Birth____________________________ Sex___________

Name of Parent/Guardian____
Address____
Tel. Number (Home)____________________Tel. Number (Work)__________________
Tel. Number (Where parent/guardian can be reached in an emergency):_______________

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

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality): Please list al medicines the child is receiving including those given during the school day.)

1. ________________2.__________________3. ________________4._________________
My son/daughter is known to have the following allergies:_______________________________

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Consent

1. I give permission for my son/daughter to have the school nurse give the following medicine:
________________________ prescribed by__________________________________to
(Name of medicine) (Licensed prescriber)

____.
(Name of Student)

2. I give permission for my son/daughter to self administer medication if the school nurse determines it is safe and appropriate. Yes_____ No_____

3. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medicine administration, e.g. adverse side effects, as she determines necessary for my sons/daughters health and safety. Yes_____ No_____ Any restrictions on release? ____

(Please note: I understand that I may retrieve the medicine from the school at any time and that the medicine 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.)

Signature of Parent/Guardian____
Relationship to Student ____