WRITTEN PARENT/GUARDIAN CONSENT
FOR MEDICATION ADMINISTRATION

(NOTE: One copy of this form must be completed for each prescribed medication.)

General Information

Student __________________________Date of Birth ______________Grade ___________

Name of Parent/Guardian ____

Address ____

____

Home Telephone # ____________________Work Telephone # _____________________

Other number where parent can be reached in case of emergency ___________________

Other person to be notified in case of emergency if parent/guardian is unavailable:

Name _______________________________Telephone ___________________________

Relationship __________________________

My son/ daughter is currently receiving the following medications (to be completed if not in violation of confidentiality): (Please list all medicines the child is receiving, including those given during the day.)
1. ________________2. ________________3. _________________4. _________________

My son/ daughter is known to have the following allergies: ________________________

* *

Consent

A. I give permission to have the school nurse or school personnel designated by the school nurse give the following medicine ____________________ (medication) prescribed by __________________________ (Licensed Prescribed) to _________________________________ (Student).

B. I give permission to have the school nurse to share with appropriate school personnel information relative 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 _______List any restrictions on sharing information______________

(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 _________________________________Date_____________

Relationship to Student ______________________________________