

**WRITTEN PARENT / GUARDIAN CONSENT
FOR MEDICATION ADMINISTRATION**

General Information

Name of Student _____ School: _____ Grade: _____
Date of Birth: _____ Sex _____

Name of Parent/Guardian: _____
(Please print)

Address: _____
Phone (Home): _____ Work: _____
Phone (parent/guardian in **case of emergency**): _____

My son/daughter is currently receiving the following medications (complete if not in violation of confidentiality): Please list all 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 the school nurse (or designated school personnel, on field trips) to give the following medicine _____

(Name of Medicine)

prescribed by

_____ to _____
(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/he determines necessary for my son/daughter's 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: _____ Date: _____

Relationship to Student: _____