Parent/Guardian Consent for <u>Prescription Medication</u>

Student's Name ______________________________ DOB ___/___/___
Address ______________________________ Grade ____

Parent/Guardian name: Father ______________ Mother ______________
Telephone number (home): Father ______________ Mother ______________
Telephone number (work): Father ______________ Mother ______________
Cell number: Father ______________ Mother ______________
Other person(s) to notify in case of an emergency:
Name ______________________ Telephone number ______________
Name of licensed prescriber ______________ Telephone number ______________

My son/daughter is currently taking the following medications (to be completed if not in violation of confidentiality)

____

My son/daughter has the following food or drug allergies:

____

I consent to have the school nurse or school personnel designated by the school nurse administer the following medication:

______________________ ______________________ ______________________
Name of medication Amount Time to be given

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

I give permission to the school nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

I understand that 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 the termination of the order or one day beyond the close of school.*

Parent/Guardian Signature ______________________________ Date ___/___/___
Relationship to Student ______________________________