



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

General Information

Name of Student: _____ Date of Birth: _____

Name of Parent/Guardian: _____

Address: _____

Telephone Numbers: Home _____ Cell _____

Work _____ Emergency _____

Other person(s) to be notified in case of medication emergency:

Name: _____ Telephone number: _____

Relationship to Student: _____

My son/daughter is currently receiving 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 medication prescribed by:

_____ to _____
Licensed Prescriber Student's Name

I give permission for my son/daughter to 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 medication administration as he/she determines appropriate for my son's/daughter's health and safety. I understand 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 termination of the order or one week beyond the close of school.

Parent/Guardian Signature: _____ Date: _____

Relationship to Student: _____

Address: _____