

# Medication Consent

To be completed by Parent or Guardian

## Student Information

Name and Address	Date of Birth
	Grade

## Parent/Guardian

Name(s)	Home Phone	Work Phone	Cell Phone
---------	------------	------------	------------

## Other Person(s) to be notified in case of emergency

Name(s)	Home Phone	Work Phone	Cell Phone
---------	------------	------------	------------

## My son/daughter is currently receiving the following medications

Complete only if not in violation of confidentiality

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

Describe

## Consent

1) I consent to have the school nurse or school personnel designated by the school nurse administrator the medication prescribed by:  Licensed Prescriber Name:	Yes
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 information relevant to the prescribed medication administration as he/she determines appropriate for my son/daughter's health and safety.	Yes
4) 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.	Yes

## Signature

Parent/Guardian	Date	Relationship to Student
-----------------	------	-------------------------