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:_____

Home Phone:_____ Work Phone:_____

Tel. number (where parent/guardian can be reached in case of emergency):_____

Other person, if any, 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 school day.)

1._____ 2._____ 3._____ 4._____
My son/daughter is known to have the following allergies:_____
_____

Consent

1. I give permission to have the school nurse or school personnel designated by the school nurse give the following medicine_____prescribed by
(Name of Medicine)
_____ to_____.
(Licensed Prescriber) (Name of Student)

2. 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's/daughter's health and safety.

Signature of Parent/Guardian_____
Relationship of Student_____Date_____