

School Union 61

BRIMFIELD - BROOKFIELD - HOLLAND - STURBRIDGE - WALES

WRITTEN PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

General Information

Name of Student: _____ School: _____ Grade: _____

Date of Birth: _____ Sex: _____

Name of Parent/Guardian: _____

Address: _____ (Please Print)

Tel. Number (Home): _____ Tel. Number (Work): _____

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

Other Persons, if any, to be notified in case of emergency if parent/guardian is unavailable:

Name: _____ Telephone: _____

Relationship: _____

My son/daughter 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)

(Licensed Prescriber)

to _____

(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 child'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 the termination of the order or one week beyond the close of school).

Parent/Guardian Signature

Relationship to Student

Date