

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:

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 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: \_\_\_\_\_

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Consent

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 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 son's/ daughter'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 termination of the order or one week beyond the close of school.)

Signature of Parent/ Guardian \_\_\_\_\_

Relationship to Student \_\_\_\_\_

Date \_\_\_\_\_