WRITTEN PARENT/GUARDIAN CONSENT
FOR MEDICATION ADMINISTRATION

Name of Student: _____ School:_____ Grade:_____
Date of Birth:_____ Sex:_____

Name of Parent/Guardian:_____
(Please Print)
Address:_____
Street City/Town State Zip Code
Tel. Number (Home):_____ Tel. Number(Work):_____
Tel. Number (Parent/Guardian can be reached for 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. (Please Circle One) 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. (Please Circle One)
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:_____
Relation to Student:_____ Date:_____

MDPH Sample – 4/ 93