SCHOOL HEALTH SERVICES
MEDICATION DELIVERY IN SCHOOLS

PARENTAL PERMISSION/CONSENT to administer medications in school setting:

Name of Student_____ Date of Birth_____ Sex_____

Address_____ School_____ Grade/Rm#_____

Name of Parent/Guardian_____ Home tel.#_____

Work tel.#_____ Cell tel.#_____ Emergency tel.#_____

Other person(s) to be notified in case of an emergency if unable to reach parent/guardian:

Name_____ Relationship to student_____ Tel.#_____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality) **Please list all medications 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:_____

1. I give permission to have the school nurse or school personnel designated by the school nurse to give the following medication_____prescibed by

_____**TO**_____.

(Licensed Prescriber) (Name of Student)

2. I give permission for my son/daughter to self-administer their medication if the school nurse determines it is safe. Yes_____ No_____

3. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medication administration, e.g. adverse side effects, as she/he determines necessary for my son/daughter's health and safety.

Yes_____ No_____ Any restriction on release_____

4. I give permission for my son/daughter to be photographed by the nurse for the medication program.

Yes_____ No_____

5. I give permission for my son/daughter's medication packet to be filed with their school health record

Yes_____ No_____

Please note: I understand that I may retrieve the medication or child's photo from the school at any time and that the medication and photo 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.

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Signature of parent/Guardian **Date**

Revised 8/2011
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