White Oak SCHOOL
533 North Road
Westfield, MA 01085
(413) 562-9500

Parent/Guardian Consent for Medication Administration

A separate form must be completed for each prescribed medication.

General Information

Student _____ Date of Birth _____ Grade _____
Printed name of Parent/Guardian _____
Home Phone _____ Work Phone _____
Cell or Other Emergency Contact Number _____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality). Please list all of your child's daily and as needed medications _____

_____

_____

My son/daughter has the following allergies _____

Consent

I give permission to the school nurse or school personnel designated by the school nurse, to give the following medication _____
ordered by (name of licensed prescriber) _____
to (student's name) _____

I understand that I must supply the school with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist.
I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the end of the school year.

I give permission to have the school nurse share with the appropriate school personnel information relative to the prescribed medicine administration, e.g., adverse side effects, as he/she determines necessary for my son's/daughters health and safety.
Yes _____ No _____ List any restrictions on sharing information _____

_____

Signature of Parent/Guardian _____

Relationship to Student _____ **Date** _____