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**____________________

Revised 6/2016