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

**2023-2024**

# Parent/Guardian Consent for Medication Administration

**A separate form must be completed for each prescribed or OTC 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):**

_____

**I understand that I must supply the school with the prescribed or OTC medication in the original container dispensed and properly labeled by a physician, the pharmacy, or the company label in the case of over the counter (OTC) medications.**
**I understand that I may retrieve the medication from the school at any time and that the medication may be destroyed if it is not picked up within one week following termination of the medication order or if not picked up by the end of the school year.**

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

**Signature of Parent/Guardian** _____

**Relationship to Student** _____ **Date** _____