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

2024 - 2025

Parent/Guardian Consent for Medication Administration

A separate form must be completed for each prescribed or OTC medication.

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 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** _________________

Reviewed 6/2024