PARENT/GUARDIAN CONSENT **FOR ADMINISTERING MEDICATION AT SCHOOL**

(TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN)

Student Name:_____ Birthdate:_____

Sex: _____ School: _____ Grade: _____Teacher:_____

Parent/Guardian:_____ Relationship to student: _____

Phone numbers: (home)_____ (cell) _____ (work)_____

Students Mailing Address:_____
Street City St. ZIP

Emergency contacts if Parent/Guardian is not available:
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

List the **student's allergies** (medications, foods, etc…): _____
_____

1. I hereby give consent for the school nurse or the designated unlicensed trained personnel to administer_____ to _____
Name of Medication Name of Student

As prescribed by _____.
Name of Doctor

2. I give permission to the school nurse to share with appropriate school personnel information (such as adverse side effects) relative to the above mentioned medication as the nurse deems necessary for the above mentioned child's safety. YES: _____ NO: _____

3. I understand that I may only pick up medication from the school, prior to the end of the school year, at the discretion of the school nurse.
YES: _____ NO: _____

4. I understand that at the end of the school year I must pick up any unused medication within 3 working days after the last day of school. I understand that if the medication is not picked up within 3 working days it will be destroyed. YES: _____ NO: _____

Signature of Parent/Guardian: _____

Relationship to student: _____ Date: _____