MEDFORD PUBLIC SCHOOLS
Health Services Department

Parent/Guardian Authorization for Prescription Medication Administration

Student's name_____ Date of Birth_____

Parent/Guardian name_____

Telephone -- Home _____

Telephone -- Work _____

Telephone -- Mobile _____

Other person(s) to be notified in case of emergency:

Name_____ Telephone_____

My child is currently receiving the following medications (to be completed if not in violation of confidentiality):_____

My child has the following food or drug allergies:_____

I consent to have the school nurse or school personnel designated by the school nurse administer the medication prescribed by:

_____ to _____
(Licensed Prescriber) (Student's Name)

☐ I give permission for my child to self-administer medication, if the School Nurse determines it is safe and appropriate. ____ Yes ____ No

☐ I give permission for the school nurse to attach a photograph of my child to the student health record for identification purposes.

☐ I give permission for the school nurse to share information relative to the prescribed medication administration as the school nurse determines appropriate for my child's health and safety.

☐ I understand that I may retrieve the medication from school at any time; *however, the medication will be destroyed if it is not picked up within **one week** following the termination of the order or the end of the school year.*

Parent/Guardian signature_____ Date_____

Relationship to the student_____

Address_____