

## Parent/Guardian Authorization For Prescription Medication Administration

Student's name \_\_\_\_\_

Parent/Guardian printed name \_\_\_\_\_

Telephone number—Home: \_\_\_\_\_ Cell Phone number \_\_\_\_\_

Telephone number—Work: \_\_\_\_\_

Telephone number—Emergency: \_\_\_\_\_

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

Name(s): \_\_\_\_\_

Telephone number(s): \_\_\_\_\_

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

\_\_\_\_\_

My son/daughter 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 son/daughter to self-administer medication, if the school nurse determines it is safe and appropriate.

\_\_\_\_ Yes \_\_\_\_ No

I give permission to the School Nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

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

Parent/guardian signature \_\_\_\_\_ Relationship to

Student \_\_\_\_\_

Address: \_\_\_\_\_