Sippican School

16 Spring St, Marion, MA 02738 / Phone: (508)748-0100 FAX: (508)748-1953

Parent/Guardian Authorization

For Prescription Medication Administration

Student's name/DOB_____ Grade_____

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

(List all medications your child will take at school here):_____

_____

prescribed by:

_____ to _____

Licensed Prescriber #1 *Student's Name*

_____ to _____

Licensed Prescriber #2 *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 beyond the close of school.

Parent/guardian signature_____ Date: _____

Relationship to Student_____