DUDLEY-CHARLTON REGIONAL SCHOOL DISTRICT

Written Parent/Guardian

Consent for Medication Administration

General Information

Name of Student: _____Date of Birth: _____

School: _____Grade:_____

Name of Parent/Guardian: _____

Address:_____

Home Telephone#: _____ Work Telephone#: _____

Please note any other medication the student is currently receiving: _____

_____

Please note any allergies: _____

Consent

1. I give permission for the School Nurse or designated school personnel to administer the following medication:

Name of Medication: _____

Licensed Prescriber: _____

2. I give permission for the School Nurse to share with appropriate school personnel information relative to the prescribed medication (e.g., adverse side effects) as she/he determines necessary for my student's health and safety.

Yes ⬜ No ⬜Any restrictions on release: _____

(Please note: This medication may be retrieved from the school·at any time. Medication that is not picked up within one week after the school year ends, will be disposed of by the School Nurse.)

3. If the School Nurse has evaluated the student's health status and abilities, and has deemed self-administration of this medication safe and appropriate, I give permission for the student to self-medicate. (*Must have MD order for self administration & have a completed DCRSD Self-administration contract with the School Nurse)*

Yes ⬜ No ⬜

Signature of Parent/Guardian: _____

Relationship to Student: _____Date:_____