DANVERS PUBLIC SCHOOLS

Department of Student Services

WRITTEN PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

General Information

Student Name:_____ School:_____ Date: _____
Date of Birth: _____ Sex: _____
Address: _____
Home Tel. Number-_____
Name(s) of Parent(s)/Guardian(s): _____
(please print)
Emergency, Cell and/or Work Tel. Number(s):_____
_____
_____
Other persons, if any, to be notified in case of emergency if parent/guardian is unavailable: _____
Telephone: _____
_____
My son/daughter is currently receiving the following medication(s) (to be completed if not in violation of confidentiality). Please list all medication the child is receiving, including those given during the school day:
1._____ 2. _____ 3. _____
_____
My son/daughter is known to have the following allergies: _____
_____

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Consent

1. I give permission to have the School Nurse (or school personnel designated by the school nurse) give the following medication _____ prescribed by _____ to _____.
2. I give permission for my son/daughter to self-administer medication if the school nurse determines it is safe and appropriate.
   _____ Yes _____No
3. I give permission to the school nurse to share, with appropriate school personnel, information relative to the prescribed medication administration, e.g., adverse side effects, as she deems necessary for my son's/daughter's health and safety.
   _____Yes ____No Any restrictions: _____

(Please note: I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within 1 week following termination of the order or 1 week beyond the close of school)

Signature of Parent/Guardian:_____
Date: _____