Danvers Public Schools
64 Cabot Rd.
Danvers, MA 01923

Written Parent/Guardian Consent For Medication Administration

General Information

Name of Student:_____ School:_____ Grade:_____
Date of Birth:_____ Sex:_____

Name of Parent/Guardian:_____
(please print)

Address:_____

Telephone Number (home):_____Telephone Number (work):_____
Telephone Number (where parent/guardian can be reached in case of emergency):_____

Other persons, if any, to be notified in case of emergency if parent/guardian is unavailable:
Name:_____ Telephone:_____
Relationship:_____

My son /daughter is currently receiving the following medications (to be completed if not in violation of confidentiality): Please list all medicines the child is receiving, including those given during the school day.

1._____ 2._____ 3._____ 4._____

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 medicine_____ prescribed by
(name of medicine)
_____ to _____.
(Licensed Prescriber) (Name of Student)

2. I give permission for my son/daughter to self-administer if the school nurse determines it is safe and appropriate. Yes_____ No_____

3. I give permission to the school nurse to share with appropriate personnel information relative to the prescribed medicine administration, e.g., adverse side effects, as he/she determines necessary for my son's/daughter's health and safety.
Yes_____ No_____ Any restrictions on release_____

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

Signature of Parent/Guardian_____
Relationship to Student_____ Date_____