SOUTHERN BERKSHIRE REGIONAL SCHOOL DISTRICT

WRITTEN PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

General Information

Name of Student: _____ School: _____ Grade: _____

Date of Birth:_____ Sex: M F N (circle one)

Name of Guardian: (please print) _____

Address: _____

Telephone Number - Home: _____ Cell: _____ Work: _____
(Circle preferred number to be reached in case of emergency)

Other persons, if any, to be notified if parent/guardian is unavailable:

Name: _____ Telephone #: _____

Relationship: _____

My child is currently receiving the following medications (to be completed if not in violation of confidentiality). In addition, please list all medications the child is receiving, including those given during the school day.

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

My child is known to have the following allergies: _____

Consent

1. I give permission to have the school nurse or school personnel designated by the school nurse give the following medicine _____ prescribed by _____ to _____.

2. I give permission for my child 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 medicine administration, e.g., adverse side effects, as the nurse determines necessary for my child'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 following termination of the order or one week beyond the close of the school.)

Signature of Parent/Guardian _____ Date _____

Relationship to Student _____