HAVERHILL PUBLIC SCHOOLS

Parental/Guardian Consent and Medication Administration Plan

Name of Student: _____ Sex: _____ Date of Birth: _____
School: _____ Grade: _____ Year of Graduation: _____
Diagnosis: _____ Food/Drug Allergies: _____
Other Medications taken by student: _____
Parent/Guardian Name: _____ Home Phone: _____ Work Phone: _____
Name of Licensed Prescriber: _____ Business Phone: _____

In case of emergency, if parent not available, please notify:

Name: _____
Address: _____ Telephone #:_____

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I give my permission to have the school nurse or designated school personnel to give the following medication to my child during school hours.

Name of Medication: _____ Start Date: _____ End Date: _____

Dosage: _____ Route: _____ Frequency: _____ Time: _____

Specific Directions: _____

Possible side effects of Medication: _____

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Medication Tracking

Intake Data						**Retrieved/Discarded**	
Date						Date	
Quantity						Quantity	
Rec'd by						Retrieved by	
Delivered by						Discarded by	

Required Storage conditions: _____
Plan for field trips: _____
Plan for monitoring medication, if needed: _____

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/he determines necessary for my son's/daughter's health and safety. _____YES _____NO

I understand that I may retrieve the medicine from the school at any time and that the medicine will be discarded if it is not picked up within one week following termination of the order or on the last day of school.

I consent to having forms for this medication filed in my child's health record. ___YES ___NO
I wish forms for this medication kept separate from my child's health record ___YES ___NO

Parent/guardian signature: _____ School nurse signature: _____
Date: _____ Date: _____