HAVERHILL PUBLIC SCHOOLS HEALTH SERVICES

PARENTAL/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

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

School: _____ Grade: _____ Year of Graduation: _____

Diagnosis: _____ Food/Drug Allergies: _____

Other Medications Taken by Student: _____

Parent/Guardian Name: _____ Cell #: _____ Work #: _____

Name of Licensed Provider: _____ Business Ph.: _____

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

Home #: _____ Cell #:_____ Work #: _____

Medication _____

Dose _____ **Frequency** _____ **Time** _____

Date Ordered _____ **End Date** _____

Specific directions (i.e. take with food) _____

Storage: Room Temp. Refrigerated Other Instructions: _____

Potential Side effects _____

All medications must be stored in a prescription bottle labeled by the pharmacy.

PARENT/GUARDIAN CONSENT

I give consent for the above medication to be administered by the school nurse. I give permission for the school nurse to share information relevant to the prescribed medication as he/she determines appropriate for my child's health and safety. **Yes No**

I give permission for the school nurse to delegate this medication to a trained staff member to be administered to the student on the day of a field trip. **Yes No**

I give permission for my child to self administer medication. If yes, additional guidance and documentation will be provided by the school nurse. **Yes No**

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

Parent/ Guardian Signature: _____ Date: _____

School Nurse Signature: _____Date: _____