MAYNARD

PUBLIC SCHOOLS

HEALTH SERVICES DEPARTMENT

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School: _____
Teacher: _____
Grade: _____

PARENT/GUARDIAN
CONSENT for MEDICATION ADMINISTRATION

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

Parent/Guardian Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

In case of emergency, if parent/guardian is unavailable, please contact:
Name: _____ Phone: _____

My child is currently taking the following medications:
1. _____ 2. _____ 3. _____ 4. _____

My child is known to have **allergies** to: _____

CONSENT

1. I give permission to have the school nurse or school personnel designated by the school nurse give:

   _____ (Name of Medication), _____ (Dose), prescribed by _____ (Licensed Prescriber/Physician),

   to _____ (Student Name) at _____ (Time to be Given).

2. I give permission for my son/daughter to self-administer medication if the school nurse determines it is safe and appropriate. YES ____ NO ____

PLEASE NOTE: Medication may be retrieved from the school at any time. Medication will be destroyed if it is not picked up within one (1) week of termination of the order or one (1) week beyond the close of school.

Parent/Guardian Signature: _____

Relationship to Student: _____ Date: _____