Frontier Regional and Union #38 School Districts / Conway, Deerfield, Sunderland, & Whately

PARENT / GUARDIAN CONSENT For Medication Administration

General Information

Name of Student: _____ School: _____

Date of Birth: _____ Grade: _____ Sex:_____ School Year: _____

Parent/Guardian printed name: _____

Person(s) to contact in case of emergency(Please put name / number) :

1. _____
2. _____
3. _____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

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

My son/daughter has been ***diagnosed*** with the following allergies: _____

_____

_____

CONSENT

1. I consent to have the School Nurse or school personnel designated by the School Nurse administer the following medication _____
   (Medication)
   prescribed by _____to _____.
   (Licensed Prescriber) (Student's Name)

2. I give permission for my son/daughter 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 relevant to the prescribed medication administration as he/she determines is necessary for my son's / daughter's health and safety.

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or at the finish of the school year.

Parent/guardian signature: _____

Relationship to Student: _____ Date: _____