

**KING PHILIP REGIONAL SCHOOL DISTRICT
WRITTEN PARENT/GUARDIAN CONSENT
FOR MEDICATION ADMINISTRATION**

General Information

Name of Student: _____ Grade: _____

Date of Birth: _____ Name of Parent/Guardian: _____

Address: _____

Home Phone: _____ Work Phone: _____

Other Phone # where parent/guardian can be reached: _____

My son/daughter is currently receiving the following medications: _____

My son/daughter is known to have the following health issues (include allergies): _____

Consent

1. I give the school nurse permission to administer the following over the counter medications (circle): Tylenol Ibuprofen Tums Sudafed Benadryl if determined necessary by the school nurse.

Signature/comments: _____

2. My son/daughter must take the following prescribed medications while in school:

3. Dosage: _____ 4. Time to administer: _____

5. I give permission for my son/daughter to self administer the medication if the nurse determines it is safe and appropriate (inhalers, insulin injections). Yes No

6. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medications or health issues, e.g., adverse side effects to observe for, as determined necessary for my son's/daughter's health and safety. Yes No Any restrictions of release: _____

Please note: I understand that I may retrieve the medication from the school at any time and must be picked up at the end of the school year. The medication will be destroyed if not picked up within one week beyond the close of school.

Signature of Parent/Guardian: _____

Date: _____

11/05