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:

   _________________________, _______________, prescribed by ______________________,
   (Name of Medication) (Dose) (Licensed Prescriber/Physician)

   to ____ at ______________________.
   (Student Name) (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: _____________