PLAINVILLE PUBLIC SCHOOLS

Parent/Guardian Authorization For Medication Administration In School

Student's name_____ Date of Birth_____

Address _____Plainville, MA. O2762 Grade ____ Teacher _____

Parent/Guardian printed name_____

Telephone number – Home ( ) _____Work ( )_____
Cell ( ) _____

Other person(s) to be notified in case of medication emergency:

Name:_____ Telephone number: ( )_____

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

_____

My son/daughter has the following food or drug allergies:

_____

I consent to have the school nurse or school personnel designated by the school nurse administer the medication prescribed by:

_____ to _____
Licensed Prescriber Student's Name

I give permission for my son/daughter to self-administer medication, if the school nurse consultant determines it is safe and appropriate.

_____Yes _____No

I give permission to the nurse consultant to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

I understand medication is not dispensed in school on half days and I may retrieve the medication from the school at any time. Medication will be destroyed if it is not picked up within one week following termination of the order or by one o'clock on the last day of school.

Parent/Guardian Signature_____ Date:_____

Relationship to Student_____