WESTON
PUBLIC SCHOOLS WESTON, MASSACHUSETTS 02493 • PHONE 781-786-5830
FAX 781-786-5839
HEALTH SERVICES

PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

Student Information

Name of Student: _____D.O.B._____

School & Grade: _____ Homeroom Teacher or Class: _____

Emergency Information

Parent/Guardian:	_____	Parent/Guardian:	_____
Home Phone:	_____	Home Phone:	_____
Work Phone:	_____	Work Phone:	_____
Cell Phone:	_____	Cell Phone:	_____
Physician's Name:	_____	Phone:	_____

In case of emergency, please contact: *(include name, relationship to student and phone number*):

1. _____
2. _____
3. _____

All current medications taken at home

Name of Medication	Dosage	Time

Medications to be given at school (if any)

Name of Medication	Dosage	Time

My child is known to have the following allergies: _____

CONSENT

1. I give permission to have the School Nurse or school personnel designated by the School Nurse give the following medicine: _____ prescribed by: _____ to my child.
2. I give permission for my child to self-administer inhaler or epi-pen 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 relative to the prescribed administration; e.g., adverse side effects, as she/he determines necessary for my child's health and safety.
4. I give permission for delegated school personnel to administer required medication on field trips. Yes_____ No_____

(Please note: I understand that I may retrieve the medicine from the school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.)

_____ _____
Parent/Guardian Date

_____ _____
Parent/Guardian Date