Dennis-Yarmouth Regional School District

Parent/Guardian Consent for Medication Administration

Name of Student _____ Date of Birth _____

Name of Parent/Guardian printed name_____

Address_____ Grade_____

Telephone Number (home)_____ Cell #_____

Telephone Number (work) _____

Telephone Number where parent can be reached in case of emergency_____

Other person(s) to be notified in case of emergency when parent/guardian is unavailable:
Name_____ Phone # _____Relationship_____

My son/daughter is currently receiving the following medication: (to be completed if not in violation of confidentiality. Please list all medications the child is receiving including those given during the school day.

1._____2. _____3._____4._____

My child has the following allergies:_____

Medication must be delivered in the proper prescription container, and may be retrieved by the parent/guardian at any time: however, the medication will be destroyed if it is not picked up by the close of school.

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Consent

I give permission to have the school nurse or school personnel designated by the school nurse give the following medicine: _____prescribed by _____(_licensed

prescriber) to name of student_____.

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

I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medication administration as he/she determines necessary for my son's/daughter's health and safety. Yes_____ No_____ Any restrictions on release_____

Signature of Parent/Guardian_____ **Date**_____

Relationship to Student_____