ATTLEBORO PUBLIC SCHOOLS
Attleboro, MA

PARENT / GUARDIAN AUTHORIZATION
For Medication Administration

Student's Name _____ Date of Birth _____

Sex _____ School _____ Grade _____

Name of Medication to be administered in school: _____

My son/daughter is also currently taking the following **medications. –** Please include any "over-the-counter" medications and doses. (To be completed if not in violation of confidentiality)

_____

My son / daughter has the following food, drug, or other **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

Parent / Guardian Printed Name _____

Telephone number: Home _____ Cell _____

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

Name _____ Telephone number _____Cell #:_____

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 information relevant to the prescribed medication administration as he/she determines appropriate for my son's /daughter's health and safety (including busing and food services if necessary).

I understand I may retrieve the medication from the school at any time: however, the medication will be destroyed if it is not picked up within one week following termination of the order or the last day of school.

Parent/Guardian Signature _____ Date _____

Address _____ Relationship to Student _____