

**Parental Consent
For Medication Administration**

Student's name _____

Parent/Guardian printed name _____

Telephone Phone#: _____ Work Phone#: _____ Other person(s)

to be notified in case of medication emergency:

Name: _____ Telephone #: _____

Student allergies:

My son/daughter is currently receiving the following medications:

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Name and phone number of the prescribing health care practitioner:

I, _____, (parent or guardian) gives permission to authorize the school nurse or school personnel to administer medication to my child as indicated above.

I give permission to the School Nurse to share information relevant to the prescribed medication administration to school staff as he/she determines it is appropriate for my son's/daughter's health and safety.

Parent/Guardian Signature _____ Date _____