

Granby Public Schools

Written Parent/Guardian Consent for Medication Administration

Name of Student: _____ Grade: _____
School: _____ Date of Birth: __/__/__ Sex: _____

Name of Parent/Guardian: _____
(Please print)

Address: _____

Home Telephone number: _____ Work Telephone number: _____
Telephone number in case of Emergency: _____

Alternative Person to be notified in case of Emergency if Parent/Guardian is unavailable:

Name: _____ Telephone: _____
Relationship: _____

My Son/Daughter is currently receiving the following medications: (to be completed if not in violation of confidentiality: (Please list all medicines the child is receiving, including those given during the school day):

- 1. _____ 2. _____
- 3. _____ 4. _____

Any known allergies: _____

CONSENT

- 1. I give permission for the school nurse or school personnel designated by the school nurse to give the following medication _____ (Name of medication)
Prescribed by _____ to _____
(Licensed prescriber) (Name of student)
- 2. I give permission for my son/daughter to self administer medication 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 medicine administration, i.e. adverse side effects, as she/he determines necessary for my child's health and safety.
YES _____ NO _____ Any restrictions on release _____

*** (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.)*

Signature of Parent/Guardian: _____

Relationship to Student: _____ Date: __/__/__

Adopted January 10, 2005

Granby Public Schools – 2004

