ESSEX NORTH SHORE
AGRICULTURAL & TECHNICAL SCHOOL

PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

Student's Name ______________________________ Date of Birth ____________________

Name of Parent/Guardian ____
(please print)

Telephone Number – Home ________________________

Telephone Number – Work ________________________

Telephone Number – Emergency ________________________

Other Person(s) to be notified in case of medical emergency:

Name ______________________________ Telephone ____________________

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

____

My son/daughter has the following food or drug 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 Name

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 relative to the prescribed medication administration as he/she determines appropriate for my son's/daughter/s health and safety.

I understand that I may retrieve the medicine from the school at any time; ***however, the medicine will be destroyed if 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 ____________________

Address ____
Street City State Zip Code