Barnstable Public Schools

Parent/Guardian Consent for Prescription Medication Administration

Student's name _____ Date of Birth _____

Parent/Guardian printed name _____

Telephone number- Home _____ Cell # _____

Telephone number- Work _____

Telephone number- Emergency _____

Other person(s) to be notified in case of medication emergency:
Name _____ Telephone number _____

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

_____

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.

My son/daughter has the following food or drug allergies:

_____

I consent to have the school nurse or school personnel designed by the School Nurse administer the medication prescribed by:

_____
Licensed Prescriber

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.
_____ Yes _____ No

Parent/Guardian signature _____ Date _____