St. Stanislaus School

WRITTEN PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

GENERAL INFORMATION

Name of Student: _____School:_____

Date of Birth:_____Sex:_____Grade:_____

Name of Parent/Guardian: _____
(Please Print)

Address: _____

TO BE COMPLETED BY PARENT
CONSENT

1. I give permission to have the school nurse or school personnel designated by the nurse to give

_____prescribed by_____
(Name of medication) (Licensed prescriber)

to_____.
(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, e.g., adverse side effects, as she/he determines necessary for my son's/daughter's health and safety.
Yes_____ No_____ Any restrictions on release_____

4. I give permission for the school nurse to delegate the administration of this medication to designated school personnel for all field trips that will be taken during this school year. Yes_____No_____

PLEASE NOTE: I understand that I may retrieve the medication from the school at anytime and that the medicine will be destroyed if it is not picked up within one week following termination of the order or by the last day of school. All medication must be brought into school by the parent/guardian in the appropriate container with a pharmacy label.

Signature of parent/guardian_____

Relationship to student: _____Date_____

534 Front Street, Chicopee, MA 01013
Tel.(413)592-5135*Fax(413)598-0187*e-mail ststanis@st.stanislaus.mec.edu
website www.st.stanislaus.mec.edu