

BROCKTON PUBLIC SCHOOLS

Parent/Guardian Authorization For Medication Administration In School

Student's name _____ Date of Birth _____

Address _____ Brockton, MA. 0230__

Parent/Guardian printed name _____

Telephone number – Home () _____ Work () _____

Other person(s) to be notified in case of medication emergency:

Name: _____ Telephone number: () _____

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's Name

I give permission for my son/daughter to self-administer medication, if the school nurse consultant determines it is safe and appropriate.

_____ Yes _____ No

I give permission to the nurse consultant to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

I will provide the nurse consultant with a picture of my child for positive identification.

I understand medication is not dispensed in school on half days and I may retrieve the medication from the school at any time. Medication will be destroyed if it is not picked up within one week following termination of the order or by one o'clock on the last day of school.

Parent/Guardian Signature _____ Date: _____

Relationship to Student _____