Sample Parent/Guardian Authorization

For Prescription Medication Administration

Student's name_____

Parent/Guardian printed name_____

Telephone number—Home:_____ Cell Phone number _____

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 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 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.

I understand I may retrieve the medication from the school at any time; however, the medication 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.

Parent/guardian signature_____

Relationship to Student_____

Address:_____