Scituate Public Schools

Parental/Guardian Consent for

Administration of Prescription Medication

Student Name: _____ Date of Birth: _____ Grade: _____

School: _____ Classroom / Team if applicable: _____

Parent/Guardian Name (Print): _____

Telephone: Home: _____ Work: _____ Cell: _____

Other person(s) to be notified in an emergency if the parent/guardian is unavailable:

Name: _____ Relationship: _____ Telephone: _____

Name of prescribed medication to be administered: _____

My student has the following allergies: _____

Please list all other medications your child is currently receiving: _____

I give permission for the school nurse (or appropriately trained school personnel) to administer

_____

Medication

_____ to _____

Licensed Provider Student Name

Yes____No____

I give permission for my student to self-administer his/her:

Epinephrine: ____ Asthma Inhaler: ____ Insulin: ____ other: _____ as prescribed by the physician (and if determined safe and appropriate by school nurse)

Yes____ No____

I give permission for the school nurse to share information relevant to this medication as she determines necessary for my child's health and safety:

Yes____ No____

I have reviewed the following information with the school nurse:

1. Duration of order: _____ Expiration of Medication Received: _____
2. Possible side effects: _____
3. Location/storage of medication: _____
4. Plan for field trips: _____
5. Plan for half days: _____
6. Plan for late starts: _____
7. Plan for monitoring medication: _____

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed per protocol if it is not picked up within one week following termination of the order or one day beyond the close of school - per school committee policy.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Student Signature (if applicable): _____ Date. _____

Please submit completed form to the school nurse at your student's school