Fernando M. Goulart, Executive Director

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 I 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: _____