

Our Lady of the Angels School
Written Parent / Gurardian Consent
For Prescription Medication Administration

General Information

Name of Student _____

School _____ Grade _____

Date of Birth _____ Sex: _____

Name of Parent/Guardian

(please print)

Address:

Tel. Number (Home) _____

Tel. Number (work) _____

Tel. Number (where parent/guardian can be reached in case of emergency)

Other persons, if any, to be notified in case of emergency if parent/guardian is unavailable:

Name: _____

Telephone: _____

Relationship: _____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

(Please list all medications the child is receiving, including those given during the school day.)

1. _____ 2. _____ 3. _____

4. _____

My son/daughter is known to have the following allergies:

Consent

1. I give permission to have the school nurse give _____, prescribed by _____ to _____

(Licensed Prescriber)

(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 for 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/daughter's health and safety.

Yes _____ No _____ Any restrictions on release _____

Signature of Parent/Guardian _____

Relationship to student _____

Date _____

MDPH Sample- 4/93