KING PHILIP REGIONAL SCHOOL DISTRICT
WRITTEN PARENT/GUARDIAN CONSENT
FOR MEDICATION ADMINISTRATION
General Information

Name of Student: _____ Grade: _____
Date of Birth: _____ Name of Parent/Guardian: _____
Address: _____
Home Phone: _____ Work Phone: _____
Additional Phone of Parent/Guardian _____
My son/daughter is currently receiving the following medications _____
_____ _____ _____
My son/daughter is known to have the following health issues (include allergies) _____

CONSENT

1. I give the school nurse permission to administer the following over-the-counter medications (circle):
2. *Tylenol* *Ibuprofen* *Sudafed* *Benadryl* *Tums* *Pepto Bismol* (children's)
   Signature/comments:
   _____
3. My son/daughter must take the following prescribed medications while in school.
   Medication_____ Dosage_____ Time to administer _____
   Medication_____ Dosage_____ Time to administer _____
4. I give permission for my son/daughter to self-administer the medication if the nurse determines it is safe and appropriate (inhalers, insulin injections).
   Yes _____ Medication _____
5. I give the permission to the school nurse to share with appropriate school personnel information relative to the prescribed medications or health issues. e.g, adverse side effects according to the medication being administered and order for the health/safety of my son/daughter's health. Yes _____ No_____
   Any restrictions on release, please note here:
   _____

Please note: I understand that I may retrieve the medication from the school at any time. Student medications must be picked up by the end of the school year. The medication will be destroyed if not picked up within one week beyond the close of school.

Signature of Parent/Guardian: _____ Date: _____