

**HADLEY SCHOOL DEPARTMENT
PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION**

Name of Student _____ Date of Birth _____ Class _____

Name of Parent/Guardian _____
(Please Print)

Address _____

Telephone Number (Home) _____ Work _____ Emergency _____

Other Person, if any, to notify 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.) _____
(Names of all the medication the student receives)

Medication(s) to be given at school:

Medication	Dosage	Time of Administration
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to medications/food/other (environmental): YES _____ NO _____
Please specify _____

Consent

1. I give permission to have the school nurse or school personnel (classroom teacher to administer medication(s) on field trips) designated by the school nurse give the above named medication(s) to my child during school hours. YES _____ NO _____
2. I give permission for my son/daughter to self-administer medication if the school nurse determines it is safe and appropriate. (Medication's are stored in a locked cabinet and the students MAY NOT carry any medication unless needed for emergency administration.) YES _____ NO _____
3. I give permission to the school nurse to share with appropriate school personnel, information relative to the prescribed medicine administration, e.g., adverse side effects, as he/she determines necessary for my son's/daughter's health and safety. YES _____ NO _____ Any restrictions on release? _____

I understand that I may retrieve the medicine from the school at any time and that the medicine 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.

Signature of Parent/Guardian _____ Relationship _____ Date _____