Office of the School Nurse
Southbridge Public Schools
Southbridge, Massachusetts

PARENTAL MEDICATION FORM

General Information

Student Name _____ Gender _____ School _____ Grade ____

Date of Birth _____

Name of Parent/Guardian _____
Please Print

Address _____

Home phone _____ Cell Phone _____ Work Phone _____

Other person(s), if any, to be notified in case of emergency if parent/guardian is unavailable:

Name of contact _____
Please Print

Relationship to student _____

Home phone _____ Cell Phone _____ Work Phone _____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality). Please list ALL medicines 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: _____

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Consent

1. I give permission to have the school nurse or school personnel designated by the school nurse give the following medicine _____ prescribed by _____to _____.
Name of Medicine 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 to 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 child's health and safety. (Yes) _____ (No) _____

Any restrictions on release: _____

Please note: 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 the termination of the order or one week beyond the close of school.

Signature of Parent/Guardian _____

Relationship to Student _____ Date _____