Fairhaven Public Schools

Parent/Guardian Authorization For Prescription Medication Administration

Student's name_____Grade_____

Parent/Guardian printed name_____
Address:_____

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:_____
Relationship:_____

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 give permission to have the school nurse administer the following medication(s)_____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.(If you object, please contact the school nurse.)

I understand I may retrieve the medication from the school at any time; however, the medication 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.

Parent/Guardian signature_____
Relationship to Student_____
Date:_____