Hamilton-Wenham Regional School District
Written Parent/Guardian Consent for Medication Administration

General Information

Name of Student: _____ School: _____ Grade: _____

Date of Birth: _____ Sex: _____

Name of Parent/Guardian: _____
(Please print)

Address: _____

Home Tel. Number: _____ Work Tel. Number: _____

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 number: _____

Relationship: _____

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**: _____

Consent

1. I give permission to have the school nurse or school personnel designated by the school nurse give the following

   medicine _____ prescribed by _____
   (Name of medicine) (Licensed Prescriber)

   to _____.
   (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 son's/daughter's health and safety.

   Yes _____ No _____ Any restrictions or 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 termination of the order or one week beyond the close of school.)

   Signature of Parent/Guardian _____

   Relationship to Student _____ Date _____