Saint John the Baptist Parish
19 Chestnut Street
Peabody, Massachusetts 01960
978/531-0444 FAX 978/531-3569

Parent/Guardian Authorization for Medication Administration

Student's name _____ DOB_____

Parent/ Guardian printed name _____

Home phone _____

Work phone_____

Emergency phone _____

Other person(s) to be notified in case of medication emergency

Name _____ Phone number _____

My son/daughter currently is receiving the following medications (to be completed if not in violation of confidentiality) _____
_____

My son/daughter has the following food/drug allergies _____
_____

I consent to have school nurse or school personnel designated by the school nurse administer the medication prescribed by _____ to _____.
Licensed Prescriber Student

I give permission for my son/daugher to self-administer medication, if the school nurse determines it is safe and appropriate. _____yes _____no

I give my permission for the school nurse to share information relevant to the prescribed medication administration as she determines appropriate for my child's health and safety.

I understand I may retrieve the medication from school at any time, however, the medication will be destroyed if it is not picked up within one week from the termination of the order or one week beyond the close of school.

Parent/Guardian signature _____ Date _____
Relationship to student _____
Address _____