

CONCORD MIDDLE SCHOOL
Concord, Massachusetts

PARENT / GUARDIAN AUTHORIZATION

FOR PRESCRIPTION AND NON-PRESCRIPTION MEDICATION ADMINISTRATION

Student's Name: _____ Date of Birth: _____

Parent/Guardian printed name: _____

Home Phone Number: _____ Work: _____ Emergency: _____

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

Name: _____ Phone: _____

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 consent to have the School Nurse or school personnel designated by the School Nurse administer the medication 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. _____ YES _____ NO

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: _____ Date: _____

Relationship to Student: _____

Address: _____