STOUGHTON PUBLIC SCHOOLS

232 PEARL STREET
STOUGHTON, MA 02072

PARENT/GUARDIAN AUTHORIZATION FOR MEDICATION ADMINISTRATION

Student's Name: ____ DOB: ________________

Parent/Guardian Name (please print): ____

Telephone numbers:

Home: ______________________________ Cell: ________________________________

Work: ______________________________ Emergency: ___________________________

Person(s) to be notified in case of a medication emergency in addition to the parent/guardian and licensed prescriber:

Name: ______________________________ Telephone Number: ____________________

Name: ______________________________ Telephone Number: ____________________

My child is currently receiving the following medications (to be completed if not in violation of confidentiality or contrary to the request of the parent/guardian or student that such medication not be documented):

____

My child has the following food or drug allergies: ____

I consent to have the school nurse administer the medication ____
prescribed by _______________________________.

I consent to have the unlicensed school personnel designated per the SPS policy provide appropriate support in medication administration when the school nurse is not available.	☐Yes ☐No
I understand the school nurse may contact the named licensed prescriber regarding any questions or concerns regarding this order.	☐Yes ☐No
I understand that in cases of field trips and other short term school events, the school nurse may delegate prescription medication administration to another responsible staff person. Written consent from the parent/guardian for the named staff to administer the prescription medication shall be obtained prior to the field trip or event.	☐Yes ☐No
I give permission for my child to self-administer medication, if the school nurse determines it safe and appropriate.	☐Yes ☐No
I give permission to the school nurse to share relevant information, to pertinent staff (including teachers), regarding medication administration and possible adverse effects of the medication.	☐Yes ☐No
I give permission to the school nurse to file the completed medication administration record and records pertinent to self- administration in my child's cumulative health record.	☐Yes ☐No
I understand I may retrieve the medication from the school at any time; however, the medication may be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.	☐Yes ☐No

Parent/Guardian Signature: ____________________________________ ____________________
(Date)

Relationship to Student: ____________________________________