ROCKLAND PUBLIC SCHOOLS
ROCKLAND, MASSACHUSETTS

Parent/Guardian Authorization for Prescription Medication Administration

Student's Name _____ Date of Birth _____

Parent/Guardian printed name _____

Telephone number – Home: _____

Telephone Number – Work: _____

Telephone Number – Emergency: _____

Other person to be notified in case of a medication emergency:

Name _____ Telephone _____

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 nurse administer the following medication: _____

Prescribed by: _____

I give permission for my son/daughter to self-administer medication, (such as: inhalers) if the school nurse determines it to be 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/daughter'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 following termination of the order or beyond the close of school.

Parent/Guardian signature: _____ Date _____

Address: _____

_____

I request that medication be given on early release days: ☐ Yes ☐ No

Medications may be given by a responsible adult on field trips or school related events: ☐ Yes ☐ No