QUINCY PUBLIC SCHOOLS

HEALTH SERVICES

WRITTEN PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

GENERAL INFORMATION

Name of Student: _____Date of Birth_____

School: _____Grade _____

Name of Parent/Guardian_____

Address: _____

Tel. (Cell) _____ (Work) _____(Home) _____

Other Persons to be notified in case of emergency if parent/guardian is unavailable:

Name: _____ Tel. # _____

Relationship: _____

My child is currently receiving the following medication/s:Please list all medications the child is receiving, including those given at home and during the school day

_____

My child has the following food or drug allergies:

_____

CONSENT

{ } I give permission to the school nurse to give the following medicine_____ prescribed by _____ to my child.

{ } I give permission for my child to carry his/her/their Inhaler or Epipen, if deemed appropriate by the school nurse. I understand that a backup must be kept in the nurse's office.

{ } I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medication administration if the nurse determines it is necessary for my child's health and safety. Yes ____ No____

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 the termination of the order or one week beyond the close of school.

Signature of parent/guardian X_____Date_____