

Ware Public Schools

PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

Student's Name _____

Date of Birth: _____ Grade _____

Name of Parent/Guardian _____

Phone number: _____

I consent to have the School Nurse or personnel designated by the School Nurse administer prescribed medication to my child. This includes field trips. ____Yes ____No

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 child'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. ____Yes ____No

Medication needed outside the parameters of a regular school day will be provided by the parent/guardian (band trips, sporting events, after school programs).

Signature _____ Date _____

Relationship to student _____

List of medications to be taken at school:
