WESTWOOD PUBLIC SCHOOLS
Westwood, Massachusetts

WRITTEN PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

Student Name: _____ Date of Birth: _____

Gender: _____ Grade: _____ School: _____

Parent/Guardian Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Other person, if any, to be notified in case of emergency and parent/guardian is unavailable.

Name: _____ Relationship: _____ Phone: _____

My child is receiving the following medication (to be completed if no in violation of confidentiality). Please list all medication the child is receiving, including those given during the school day.

1. _____
2. _____
3. _____
4. _____

My son/daughter is known to have the following allergies: _____

Consent

1. I give permission to have the school nurse or other designated personnel give the following medicine or treatment as prescribed by _____ (Licensed prescriber) to _____ (Name of student).

   Blood glucose test, insulin administration, blood or urine ketone testing, glucagon, hypoglycemic treatment, or _____.

2. I give permission for my son/daughter to self-administer medication if the school nurse determines it is safe and appropriate. ___ Yes ___ No

3. I give permission to the school nurse to share information with appropriate school personnel relative to the prescribed medicine administration. ___ Yes ___ No

   ___ Restrictions on release: _____

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 on the last day of school.

Parent/Guardian Signature: _____ Date: _____

Relationship to Student: _____