Bi-County Collaborative
Making It Possible

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BI-COUNTY COLLABORATIVE
WRITTEN PARENT/GUARDIAN CONSENT
FOR MEDICATION ADMINISTRATION

Name of Student: _____ **Date of Birth:** _____

School: _____ **Grade:** _____ **Sex:** _____

Name of Parent/Guardian: _____
(Please Print)
Home Phone: _____ **Other Phone:** _____

Please list all medications your child is receiving, including those to be given at school:

1. **Medication and instructions:** _____
2. **Medication and instructions:** _____
3. **Medication and instructions:** _____
4. **Medication and instructions:** _____
5. **Medication and instructions:** _____

My child has the following allergies: (include food, drugs, environmental, substance)
_____
_____

CONSENT

1. **I give permission to the school nurse or school personnel delegated by the school nurse to administer the following medication:**

Name of medication: _____ **Time:** _____
Name of medication: _____ **Time:** _____
Name of medication: _____ **Time:** _____
Name of medication: _____ **Time:** _____
Name of medication: _____ **Time:** _____
Name of medication: _____ **Time:** _____

2. **I do/do not give permission for my child to self-administer if the school nurse determines it is safe and appropriate.**

3. **I give permission for the school nurse to share information relative to the prescribed medication with school personnel as he/she determines necessary for my child's health and safety (e.g. adverse side effects).**

Please note: An adult must bring all medications to school. All medications must be in the original, labeled pharmacy container and must have a doctor's order for administration. This includes prescriptions and over the counter medications.

Signature of parent: _____ **Date:** _____