Salem Public Schools Parent Permission for Medication Administration

Student's name_____ DOB: _____

School: _____ Grade: _____

Parent/Guardian printed name: _____

Home: _____ Cell: _____ Work: _____

Other person(s) to be notified in case of medication emergency:

Name: _____ Phone: _____

Food or drug allergies: _____

*Diagnosis: _____

*Other medications taken by student: _____

* **To be completed if not in violation of confidentiality**

My son/daughter will receive the following medication in school:

_____

Dosage: _____ Frequency: _____ Route: _____

Specific Instructions (if any): _____

I consent to have the school nurse or school personnel designated by the School Nurse administer the medication prescribed by:

_____ to_____

Licensed Prescriber Student's Name

- 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 communicate directly to the licensed prescriber regarding this medication.
- 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 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.

Parent/guardian signature: _____ Date: _____