

St. James St. John School

*180 Orchard Street
New Bedford, MA 02740
Telephone (508) 996-0534
Fax 508-717-6969*

Parent/Guardian Authorization For Prescription Medication Administration

Student's name _____ Date of Birth _____ Grade _____

Parent/Guardian printed name _____

Telephone number—Home _____ Cell Phone number _____

Telephone number—Work _____

Telephone number—Emergency _____

Other person(s) to be notified in case of emergency if parent/guardian is unavailable:

Name _____ Telephone number _____

Relationship _____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

My son/daughter has the following food or drug allergies:

I consent to have the school nurse or school personnel designated by the School Nurse administer the following medication(s) _____

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 share information relevant to the prescribed medication administration, e.g., adverse side effects, as he/she determines appropriate for my son's/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 _____

Relationship to Student _____ Date _____

