Office of the School Nurse

Smith Vocational and Agricultural High School
80 Locust Street, Northampton, MA 01060
Phone: 413-587-1416 **FAX:** 413-961-5442

Parent/Guardian Consent Form for Medication Administration

Name of Student _____Date of Birth_____

Address _____ Grade _____

Name of Parent/Guardian_____

Home Phone: _____Cell Phone: _____

Work Phone: _____

Other Emergency Contact: _____Phone: _____

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My child has the following **food or drug allergies**: _____

My child is currently taking the following **medications:** _____

_____

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I give consent to the school nurse (or school personnel designated by the school nurse) to administer the following:

Medication: _____

Route: _____ Dosage: _____

Frequency: _____ Time of Administration: _____

Prescribed to (Student) _____**Prescribed by** (Provider) _____

I give permission for my child to self-administer medication, if the school nurse determines it is safe and appropriate: Yes____ No____

I give permission for the school nurse to share medication information with school staff as he/she determines is appropriate and necessary for my child's health and safety: Yes ___No___

Signature of Parent/Guardian _____Date_____