WESTPORT COMMUNITY SCHOOLS

WRITTEN PARENT/GUARDIAN CONSENT
FOR MEDICATION ADMINISTRATION

_____/ _____/_____
Name of Student Date of Birth Sex
School_____Grade_____

Name of Parent/Guardian:_____
(Please Print)
Address:_____

Home Telephone Number Work Telephone Number

_____
Telephone number where someone can be reached in case of emergency

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

_____
Name Relationship
Telephone Number_____
My son/daughter is currently receiving the following medications (to be completed if not a violation of confidentiality). Please list all medicines the child is receiving, including those given during the school day.
1._____2._____

3._____4._____

CONSENT FORM

1. I give permission to have the school nurse or school personnel designated by the school nurse to give the following medicine_____
Name of Medicine
prescribed by _____to _____
Licensed Prescriber Name of Student

2. I give permission for my son/daughter to self administer medication if the school nurse determines it is safe. Yes _____ No_____
3. I give permission to the school nurse to share with school personnel information relative to the prescribed medicine, e.g. adverse side effects as he/she determines it necessary for my son's/daughter's health and safety Yes_____No_____

4. I give permission for my son/daughter to carry their own medication (inhaler or epipen) if approved by the nurse. Yes_____No_____

Please note: 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 within one week following the termination of the order at the close of school.

_____/_____
Signature of Parent/Guardian Date