NEW HEIGHTS CHARTER SCHOOL of BROCKTON

PARENTAL/ GUARDIAN MEDICATION CONSENT FORM

Name of Student: _____ Date of Birth: _____

Grade: _____ Room Number: _____

Parent/ Guardian name: _____

Address_____

Telephone numbers: Home _____

Cell/work _____

Other person to be notified in case of medication emergency:

Name: _____ Telephone: _____

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 to administer the

Medication_____ Prescribed by: _____
(Medication name) (Licensed prescriber's name)

To: _____
(Student's name)

I give permission for my son / daughter to self-administer medication, if the school nurse determines it safe and appropriate.

YES_____ **NO**_____

I give permission to the school nurse to share information relevant to the prescribed medication administration as he/she determines approved 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 following the termination of the order, beyond the close of school, and if past expiration date.

Parent/ guardian signature: _____ Date: _____

Relationship to student_____