WRITTEN PARENT/GUARDIAN CONSENT
FOR MEDICATION ADMINISTRATION
Berkshire Hills Regional School District

Name of Student:_____School:_____Grade:_____
DOB:_____ Sex:_____

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

Phone Number (H)_____ Phone Number (W)_____Phone Number (C)_____
Phone Number (Where parents/guardian can be reached in an emergency)_____
Other persons, if any, to be notified in case of emergency if parent/guardian is unavailable. Name:_____ Telephone: _____
Relationship: _____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality) Please list all medications the child is receiving, including those given during the school day.
1._____2._____3._____4._____

My son/daughter is known to have the following allergies: _____
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Consent

1. I give permission to have the school nurse or school personnel designated by the school nurse give the following medicine _____
(name of medication)
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 and appropriate. Yes_____ No_____ .

3. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medication administration, e.g., adverse side effects, as she/he determines necessary for my son's/daughter's health and safety. Yes _____ No_____.
Any Restrictions on Release_____.

(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 termination of the order or one week beyond the close of school.)

Signature of Parent/Guardian_____
Relationship to Student_____Date_____