SOUTH SHORE REGIONAL VOCATIONAL TECHNICAL HIGH SCHOOL
SCHOOL HEALTH SERVICES

PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

Student _____ ☐ Male ☐ Female
Date of Birth_____ Grade_____ Date of Consent_____

My son/daughter has the following allergies: _____
_____

Diagnosis (if not in violation of confidentiality) _____

1. I request and give permission to the school nurse to give my son/daughter:
   Medication: _____ Dosage: _____
   Route: _____ Time of Day: _____
   Prescribed by: _____
2. I give permission for my son/daughter to self-administer (carry the medication and administer by him/herself during class/field trip) NOT in the presence of the school nurse. NOTE: Self administration is reserved for students who have an Epi-pen, enzyme supplement, inhaler or diabetic supplies as per the regulations of the Commonwealth of MA. ☐ **Not Applicable** ☐ **YES** ☐ **NO**

   If I give my permission, I understand the school nurse and I must be in agreement that my student demonstrates the ability and understands all aspects of the administration of this medication as directed. I also provide a back-up supply for the nurse to keep in the health office in the event my student does not have his/her prescribed medication/supplies in his/her possession when needed.

3. I give permission to the school to share with the appropriate school personnel information relative to the prescribed medicine administration as she determines necessary for my child's health and safety. ☐ **YES** ☐ **NO**
4. I understand that in the event of a field trip, this medication administration plan may need to be adjusted and I will contact the school nurse prior to the field trip to discuss the plan for administration.
5. I understand that I may retrieve the medicine from the school at any time. I also understand that the medicine will be destroyed if it is not picked up within one week following the termination of the order or the last day of school.

Parent/Guardian Signature_____ Date_____