Beverly Public Schools
PARENT/GUARDIAN/CAREGIVER CONSENT
For Medication Administration

Student's Name:_____ Today's Date_____

Parent/Guardian/Caregiver printed name:_____

Telephone Number (s) Home:_____ Cell:_____

Work phone:_____ Emergency number:_____

Other person(s) to be notified in case of medication emergency:

Name/relationship to student:_____

Telephone number:_____

I give permission for my student to receive the following medication(s) (to be completed if not in violation of confidentiality):_____

My student has the following food and/or drug allergies:_____

_____

Requires EpiPen: (circle one): YES / NO

I consent to have the school nurse or school personnel designated by the School Nurse administer the medication prescribed by:

_____ to _____
(Licensed Prescriber) (Student's Name)

I give permission for my student to self-administer medication, if the School nurse determines it's safe and appropriate(circle one): YES / NO

I give permission to the School Nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my student'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 within one week following termination of the order or one week beyond the close of school.

Parent/Guardian/Caregiver Signature:_____

Relationship to Student:_____

Address:_____ City:_____ State:_____