



**Beverly Public Schools
PARENTAL/GUARDIAN CONSENT
For Medication Administration**

Student's Name: _____ Today's Date _____

Parent/Guardian 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 son/daughter to receive the following medication(s) (to be completed if not in violation of confidentiality): _____

My son/daughter 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 son/daughter 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 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 within one week following termination of the order or one week beyond the close of school.

Parent/Guardian Signature: _____

Relationship to Student: _____

Address: _____ City: _____ State: _____