Fairhaven Public Schools

Parent/Guardian Authorization to Administer Prescription Medication

Student's name_____ DOB_____ Grade_____

Parent/Guardian printed name_____

Address_____

Cell Phone_____ Home Phone_____

Work Phone_____ Emergency_____

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

Name_____ Phone_____ Relationship_____

My son/daughter is currently receiving the following medications*

_____

_____

My son/daughter has the following food or drug allergies

_____

I give permission to have the school nurse administer the following medication(s)

_____ prescribed by _____

Licensed Prescriber

To _____

Student's Name

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

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. (If you object, please contact the school nurse.)

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 *Date*

_____

Relationship to Student

** to be completed if not in violation of confidentiality*