The Learning Project Elementary School
Prescription Medication Administration Consent Form

Student's Name _____ Grade _____

Parent/Guardian _____
Home Telephone _____ Cell _____
Work Telephone _____ Emergency _____

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

My son/daughter is currently receiving the following medications related to his/her allergy/Asthma (to be completed if not in violation of confidentiality):

_____

_____

My son/daughter has the following food/drug allergies:
_____

_____

_____

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

_____ to _____
Signature of Licensed Prescriber Student's Name

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

I give permission to the school nurse to share information relevant to the prescribed medication administration as 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 _____