



DIGHTON-REHOBOTH REGIONAL SCHOOL DISTRICT

SUPERINTENDENT OF SCHOOLS' OFFICE 2700

Regional Road
North Dighton, MA 02764

PALMER RIVER SCHOOL Phone: 508-252-5100 Fax: 508-252-5110

WRITTEN PARENT/GUARDIAN CONSENT
FOR MEDICATION ADMINISTRATION
GENERAL INFORMATION

Name of student: School: Grade:

Date of birth: Sex: Name of Parent/Guardian:

(Please Print)

My son/daughter is currently receiving the following medications at home

1. 2. 3. 4.

My son/daughter is known to have the following allergies:

CONSENT

1. I give permission to have the school nurse, or school personnel designated by the school nurse, give the following medication (Name of Medication) (Dosage) (Time to be Given)

prescribed by (Licensed Prescriber) to (Name of Student)

2. I give permission for my son/daughter to self-administer medication if the school nurse determines it is safe and appropriate. Yes No

3. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medication administration, e.g. adverse side effects, as she/he determines necessary for my son's/daughter's health and safety.

Yes No Any restrictions on release

Signature of Parent/Guardian

Relationship to Student Date