MARSHFIELD PUBLIC SCHOOLS
MARSHFIELD, MASSACHUSETTS 02050

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Parent Guardian Consent and Medication Administration Plan

Name of Student:	**School:**	**Grade:**	**Date of Birth:**(mm/dd/yyyy)

Name of Parent/Guardian:

Address: **Telephone (1)** **Telephone (2)**

Other persons, if any, to be notified in case of emergency if parent/guardian in unavailable:
Name/Relationship: **Telephone(1)** **Telephone(2)**

My student is currently receiving the following medication per Licensed Prescriber:

I give permission to have the School Nurse or school personnel designated by the School Nurse to administer this medication:

Name **Dose/Frequency** **Route** **Date of Order**

1.____
_
2. ____

3. ____

I give permission for my student to: self-administer medication if the School Nurse deems it safe and appropriate Yes ____ No ___ Student Demonstration to Nurse: Yes ___ No ____

I give permission for the School Nurse to share relevant information regarding medication on a need to know basis as appropriate for my student's health and safety. Yes ____ No ____

I give permission for the delegation of this medication to unlicensed properly trained staff for field trips and short term school events when the School Nurse in unavailable: Yes ____ No____

Diagnosis / Other Medications:____
(If not in violation of confidentiality)

Possible side effects / adverse reaction: ____
Specific Directions: ____
Food or Drug allergies: ______________________ Administration / storage locations:_____________

Backup Plan is the coverage per current MPSD Emergency Nursing Coverage Procedure
(**Please note:** I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within one week following the termination of the order or one week beyond the close of school.)

Signature of Parent/Guardian: _________________________________ Date: __________________

Signature of School Nurse: ___________________________________ Date: _________________

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