

CANTON PUBLIC SCHOOLS HEALTH SERVICES

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MEDICATION ADMINISTRATION PLAN and PARENT/GUARDIAN CONSENT

Student's Name: _____ DOB: _____ Grade/Teacher: _____

Parent/Guardian printed name: _____

Address: _____

Telephone: Home: _____ Work: _____

Cell: _____

Other person to be notified in case of medication emergency:

Name: _____ Phone: _____

My son/daughter is currently receiving the following medications (if not in violation of confidentiality):

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

I give permission for the school to administer (medication) _____

prescribed by: _____ to _____

Licensed Prescriber

Student

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 for the nurse to share information relevant to this medication as she determines necessary for my child's health and safety. Yes _____ No _____

Should medication be given on early release days? Yes _____ No _____

Plan for field trips: Needed on field trip Yes _____ No _____

I understand that the medication must be delivered by a responsible adult, in a properly labeled pharmacy bottle to the health office. The medication must be accompanied by a Medical Provider Permission Slip. Unused medication must be picked up within one week of the termination of the physician's order or by the last day of school or it will be discarded.

Parent/Guardian signature: _____

School Nurse signature: _____

Student signature (if applicable): _____