Parent/Guardian Authorization For Prescription Medication Administration

Lincoln- Sudbury Regional High School
390 Lincoln Road
Sudbury, MA 01776
Health Office : 978-443-9961 x 2390
Fax # 978-639-3090

Student Name: _____ DOB: _____

Parent/Guardian (print name):_____

Phone Number: Home _____ Work _____ Cell _____

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

Name: _____ Number: _____

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

_____

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

_____ to _____
Licensed Prescriber Student's Name

I give permission for my son/ daughter to self - administer medication, if the school nurse determines it is appropriate for my son's /daughter's health and safety.

Yes ____ *No* ____

I understand I may retrieve the medication from the school at anytime; 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: _____

Address: _____