SAINT JOHN THE BAPTIST SCHOOL
19 Chestnut Street
Peabody, Massachusetts 01960
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Parent/Guardian Medication Administration Consent

Student Name_____ Date of Birth_____

Parent/Guardian Name (printed)_____

Telephone Numbers: Home_____

Work_____

Cell_____

One other person to be notified in case of a medication emergency need:

Name_____ Relationship_____

Telephone Numbers: Home_____

Work_____

Cell_____

List the child's medications:_____

List the child's allergies:_____

I give consent for the school nurse or a faculty member designated by the school nurse to administer the medication prescribed by (Physician):_____ for my child(name):_____.

I give consent for my child to self administer medication, if the physician and the school nurse deem it is safe and appropriate. Yes_____ No_____

I give consent for the school nurse to share relevant information regarding the prescribed medication if deemed appropriate for the health and safety of my child. I am aware that I can retrieve the medication from the school at any time, should I see the need to do so.

Parent/Guardian Signature:_____ Date:_____

Relationship to child:_____ Address:_____