North Reading School District
Prescription Medication Administration Form

Student's Name: _____

Parent/Guardian Name: _____

Telephone Number: H _____ C _____ W _____

Other person to be notified in case of emergency: _____

Phone: _____

My child 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 child to self administer medication, if the school nurse determines that it is safe and appropriate: _____ Yes _____ No

I give permission to the school nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my child's health and safety.

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following the termination of the order.

Parent/Guardian Signature: _____

Relationship to student: _____

Date: _____