GROTON-DUNSTABLE REGIONAL SCHOOL DISTRICT

PARENTAL CONSENT FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

SECTION 1 - STUDENT INFORMATION		
Student Name: ______________________________		**DOB:** ____________
Building: ____________________	**Grade:** ________	**YOG:** _____________
Parent Name: ______________________	Home Phone: ___________________	
Cell Phone #: ______________________	Work Phone: ___________________	
List student's allergies: ____		
List other medication student is taking: ____________________________________		

SECTION 2 – MEDICATION INFORMATION			
1. Name of Medicine: ____			
2. Dose: __________________	Time(s) to be given: ______________________		
3. Route: ☐ Orally	☐ Inhaled	☐ Injected	☐ Other: ______________________
4. Start Date: __________________	End Date: __________________		

SECTION 3 – PARENTAL CONSENT	
1. I give permission for my child to self-administer the medicine if the school nurse determines it is safe and appropriate: ☐ Yes ☐ No * PLEASE NOTE: STUDENTS ARE NOT ALLOWED TO SELF-ADMINISTER CONTROLLED SUBSTANCES (I.E. RITALIN, ETC.)*	
2. I give the nurse permission to share with the appropriate school personnel information relative to the prescribed medicine administration (such as side effects) as she determines necessary for my child's health and safety: ☐ Yes ☐ No Any restrictions? Please list: __________________	
3. When appropriate, can this medicine be given to your child by designated school personnel, while participating on a field trip? ☐ Yes ☐ No	
4. I give permission to the nurse or her designee to give the above named child this medication: ☐ Yes ☐No	
Date: ________	**Parent/guardian Signature:** ___________________________
Printed Name: _________________________ **Relationship:** _____________	
Remember to pick up the medication upon completion. All medicines remaining in the nurse's office will be discarded on the last day of school.	
Please return this form to: School Nurse	