BELMONT PUBLIC SCHOOLS

Parent/ Guardian Authorization for Medication Administration

Student's Name _____

Parent/ Guardian Name _____

Home telephone number: _____

Work telephone number: _____

Cell telephone number: _____

Please give my son/ daughter the following medication in school: _____

_____

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

_____

My son/ daughter has the following drug allergies:

_____

I consent to have the school nurse or school personnel delegated 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 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 son/daughter'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 or one week beyond the close of school.**

Parent/ Guardian signature _____ Date:_____

For more detailed information regarding the Belmont Public Schools, Medication Administration Policy, please see refer to the BPS Health and Nursing Services website

Revised: 12.17