QUINCY PUBLIC SCHOOLS

Richard DeCristofaro, Ed.D.
Superintendent of Schools

HEALTH SERVICES

PARENT/GUARDIAN CONSENT for MEDICATION ADMINISTRATION

GENERAL INFORMATION

Name of Student: _____ Date of Birth: _____

Name of Parent/Guardian: _____
Address: _____ Home Phone: _____
_____ Work Phone: _____

Emergency Contact: (Person other than parent/guardian)
Name: _____ Phone: _____

MEDICATIONS (To be completed if not in violation of confidentiality)
Please list all medications that your child is receiving, including those given during the school day.
1. _____ 3. _____
2. _____ 4. _____

ALLERGIES (Known food or medication allergies)

_____

CONSENT

I give permission for administration of the following medicine _____
prescribed by _____ to _____.

I give permission for _____ to carry his/her inhaler or Epi-Pen.
I understand that a second inhaler or Epi-Pen (backup) must be in the nurse or principal's office.

I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medication administration, e.g., adverse side effects, as determined necessary for my son's/daughter's health and safety.
Yes _____ No _____ Any restrictions on release _____

PLEASE NOTE: I understand that I may retrieve the medicine from the school at any time and that the medicine will be destroyed if it is not picked up within one (1) week following termination of the order or one (1) week beyond the close of school.

Signature of Parent/Guardian_____
Relationship to Student _____ Date _____