Dudley-Charlton School District
Written Parent/Guardian Consent
For Medication Administration

General Information

Name of Student: _____Date of Birth: _____

School: _____Grade:_____

Name of Parent/Guardian: _____

Address: _____

Home Telephone #:_____Work Telephone #: _____

Please note any other medication child is currently receiving:

_____

Please note any allergies:

_____

Consent

1. **I give permission to have the school nurse or personnel designated by the school nurse give the following medicine:**

   Name of Medication: _____

   Physician: _____

2. **I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medicine administration, e.g., adverse side effects, as she/he determines necessary for my son/daughter's health and safety.**

   Yes_____ No_____ Any restrictions on release: _____

   (Please note: I understand that I may retrieve the medicine from school at any time and that the medicine will be destroyed if it is not picked up within one week beyond the close of school.)

   Signature of Parent/Guardian: _____

   Relationship to Student: _____ Date: _____