CAMBRIDGE PUBLIC HEALTH DEPARTMENT
School Health Program

CONSENT TO GIVE MEDICATION IN SCHOOL

In order for medication (prescription and non-prescription) to be given to your child during school, this form needs to be completed by both you and your child's doctor or clinic. Return the completed form to your child's school nurse.

Name of Child_____ **Date of Birth**_____ **Grade**_____ **Rm. #** _____

MEDICAL PROVIDER INFORMATION

Provider's name_____ Clinic/Practice name _____ Tel._____ Fax_____

Diagnosis_____

Medication_____

Route of administration_____ Dosage_____

Frequency_____ Time(s) of administration_____

Date of order_____ Discontinuation date_____

Specific directions or information for medication_____

Any other medical condition(s)*/Allergies_____

Consent for self-administration (provided the primary care provider/parent determine it is safe and appropriate) ☐ Yes ☐ No

Other Information (Special side effects, contraindications or possible adverse reactions; other medications being taken, specific directions for storage):

_____

Health Care Provider Signature	Please Print Name Here	Date
_____	_____	_____

PARENT/GUARDIAN INFORMATION AND CONSENT

Parent/Guardian Name_____
Tel # (H)_____
(C)_____
(W)_____
Email_____

Parent/Guardian Name_____
Tel # (H)_____
(C)_____
(W)_____
Email_____

Other person(s) to be notified in case of medication emergency:

Name:_____ Relationship:_____ Telephone #:_____

Name:_____ Relationship:_____ Telephone #:_____

Please complete each item and initial.	
I give permission to have the school nurse or school personnel designated by the school nurse administer this medication.	____Yes ____No (Please Initial)
I give permission to the school nurse to share information relevant to the prescribed medication administration as s/he determines appropriate for my child's health and safety.	____Yes ____No (Please Initial)
I give permission to the school nurse to photograph my child, to keep on file for identification purposes only.	____Yes ____No (Please Initial)
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 termination of the order or by the last day of the school.	____Yes ____No (Please Initial)

Parent/Guardian Signature	Please Print Name Here	Date
_____	_____	_____

For Clinical / Office Use Only

Nurse Signature	Please Print Name Here	Date
_____	_____	_____