COMPASS School

Dorchester, Massachusetts

Parent / Guardian Authorization

For Prescription Medication Administration

Student's Name _____

Parent / Guardian (Printed Name) _____

Telephone Number - Home _____ **Cell Phone Number** _____

Telephone Number - Work _____

Telephone - Emergency _____

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

Name _____ **Telephone Phone Number** _____

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

_____

_____

My son/daughter has the following food or drug allergies:

_____

_____

I consent to have the school nurse or school personnel designated 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's/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 _____

Relationship to the Student _____

Address _____

294 Bowdoin Street, Dorchester, MA 02122 - Phone (857) 220 - 2333 / Fax (617) 506 - 8106