

Sturgis Charter Public School



An International Baccalaureate Diploma School

MEDICATION ADMINISTRATION CONSENT FORM

(To be completed by Parent/ Guardian)

Name of Student _____

Parent/ Guardian Name _____

Telephone Number Home: _____ Cell Number: _____

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

Name: _____

Telephone Number Home: _____ Cell Number: _____

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

Medication : _____

Dosage: _____ Frequency : _____

Route of Administration: _____ Time(s) of Administration _____

I consent to have the School Nurse or school personnel designated by the School Nurse administer the medication prescribed by:

_____ to: _____

Licensed Prescriber

Student 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 give permission to the School Nurse to delegate medication administration to my child's teacher/ designee for field trips.

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 before the close of school.

Parent/ guardian Signature: _____ Date: _____