Westfield Public Schools
Parental Consent and Medication Form

AUTHORIZATION FOR MEDICATION TO BE ADMINISTERED DURING SCHOOL HOURS

Student's Name________________________________Date of Birth___________Sex______Allergies_________________

School_______________________________________Grade______________Teacher______________________________

Name of Parent/Guardian____

My son/daughter is currently taking the following medications (include all medications even those given during school hours)
1. ______________________2.________________________3.________________________ 4.______________________

Can student medicate self if determined appropriate by nurse? _______yes _______no

I request that my son/daughter be given the medication(s) described below by the school nurse as authorized by myself and my prescribed provider below.
(Please note: I understand that I may retrieve the medicine from school at any time and the medicine will be destroyed if it's not picked up by the close of school.)

___________________________________ ______________ _________________ _________________
Signature of Parent/Guardian Home phone Work phone Cell phone

___________________________________ ______________
Relationship to Student Date

Name and phone number of another person to be notified in case of emergency if parent/guardian is unavailable:

____ __________________________
Name Phone

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The following to be completed by the Physician or other Licensed Provider as authorized by Chapter 94C:
(Whenever possible, medications should be scheduled other than school hours)

Diagnosis for medication given____
Name of medication_____________________________ Route _____________ Dosage________ Time__________
Can student medicate self if determined to be appropriate by nurse? ______yes ______no

List significant side effects____

Date to start_______________________ Date to discontinue______________________

Other information____

Printed name of Licensed Provider____ Date________________

Signature of Licensed Provider____

Office phone number____________________________________ Other emergency phone number________________

School Nurse's Signature____ Date_______________