BISHOP CONNOLLY HIGH SCHOOL
373 Elsbree Street, Fall River, MA 02720
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Parental Permission for Prescription Medication Administration

Student Name ____ Date of Birth ____________________

Parent/Guardian Name (please print) ____

Phone # (Home) ________________________ Phone # (Work) ____________________________________

Phone # (Cell) __________________________

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

Name/Relationship ____ Phone # ________________________

Name/Relationship____ Phone # ________________________

My son/daughter is currently receiving the following medication(s): ____________________________________

____

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

____ To ____
Licensed Prescriber Student Name

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

I give permission for my son/daughter to self-administer medication, if the school nurse determines it is safe.
Yes __________ No __________

I give permission to the School Nurse to share information relevant to the prescribed medication(s) administration as he/she determines appropriated for my son's/daughter's health and safety. Yes _______ No _________

I give permission for my son/daughter to carry his/her own medication (inhaler, Epipen or insulin only), if approved by the nurse. Yes__________ No__________

I understand that 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 one week beyond the close of school.

Parent/guardian signature ____ Date ____________________

Relationship to student ____

Address ____

**Any additional comments: ____