



BISHOP CONNOLLY HIGH SCHOOL
373 Elsbree Street, Fall River, MA 02720
Phone: 508.676.1071 Fax: 508.676.8594
www.BishopConnolly.com

**PARENTAL CONSENT FORM 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 _____