

**2010/2011 STUDENT MEDICAL RECORD AND
CONSENT FOR MEDICATION ADMINISTRATION**

**ALL PARENTS MUST COMPLETE, SIGN, AND DATE THIS FORM
AT BOTTOM OF REVERSE SIDE**

Student Name _____

Sex _____ Date of Birth _____ Grade _____

Student Address _____
Number and Street

City _____ State _____ Zip Code _____ Home Phone _____

Cell Phones _____
(Please note which cell number belongs to which parent)

If we are unable to reach a parent in the case of an emergency, the school should contact:

Name _____ Name _____

Phone # _____ Phone # _____

Relationship to student _____ Relationship to student _____

Pediatrician _____ Phone # _____

Address _____

Health Insurance Company _____

My child is known to have the following allergies (foods, drugs, pollen, insect stings, etc.):

Has your child needed an Epi Pen or Benadryl for this allergy? Yes _____ No _____
Has your child needed the Emergency Room for this allergy? Yes _____ No _____

My child currently receives the following medications, either at home or in school. Please list diagnosis as well.
(Complete if not in violation of confidentiality.)

SEE OVER

1. I give permission for school personnel designated by the Head of School to administer _____
(name of medication)

prescribed by _____ to _____
(licensed prescriber) (name of student)

Prescription medication must come in a pharmacy-labeled bottle with the child's name on the label, the name of the medication, the dosage, how the medication is to be administered, and the frequency with which the medication should be administered, specifically during school hours.

2. I give permission for my child to self-administer medication in the presence of designated school personnel, if determined safe and appropriate. Yes _____ No _____

Prescription medication must come in a pharmacy-labeled bottle with the child's name on the label, the name of the medication, the dosage, how the medication is to be administered, and the frequency with which the medication should be administered, specifically during school hours.

3. I give permission to have school personnel designated by the Head of School administer _____
(over-the-counter medication). Written instructions must accompany this request and instructions should not exceed dosage as recommended on the manufacturer's label.

4. I give permission to have school personnel designated by the Head of School administer _____
(over-the-counter medication). Written instructions must accompany this request and instructions should not exceed dosage as recommended on the manufacturer's label.

5. I give permission to designated school personnel to share with appropriate teacher(s) information relative to the prescribed medicine administration, e.g., adverse side effects, as she/he determines necessary for my child's health and safety. Yes _____ No _____

Any restrictions on release? _____

Note: I understand that I may retrieve the medicine from the school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of the school.

Please contact Anne Kiely at 617-742-0520, ext. 10, if you will need to keep any medicine at the school, such as an Epi-Pen or asthma inhaler. You will be provided with additional forms to complete and return to the school before the first day of classes. Please contact Ms. Kiely as soon as possible for the forms, because your pediatrician or allergist will need to sign them as well.

ALL PARENTS CHECK AND SIGN BELOW

Are your child's current Physical and Immunization Forms attached? Yes ___ No ___
Any additional medical information forms attached? Yes ___ No ___

Parent/Guardian Signature _____ **Date** _____