LYNN PUBLIC SCHOOLS
School Health Services
Medication/Treatment Delivery in Schools
Parent Consent Form

PARENTAL PERMISSION/CONSENT to administer medications/treatments in school setting:

Name of Student_____ Date of Birth_____ Sex_____

Address_____ School_____ Grade/Rm#_____

Name of Parent/Guardian_____ Home tel.#_____
(Please print)

Work #_____ Cell #_____ Emergency #_____

Other person(s) to be notified in case of an emergency if unable to reach parent/guardian:

Name_____ Relationship to student_____ Cell #_____

My son/daughter is currently receiving the following medications/treatments. Please list all medications/treatments the child is receiving, including those given during the school day.
**To be completed if not in violation of confidentiality*

1._____ 2._____ 3._____ 4._____

My son/daughter is known to have the following allergies: _____

I give permission to have the school nurse or school personnel designated by the school nurse to give the following medication/treatment _____prescribed by _____TO_____.
Licensed Prescriber Name of Student

1. **I give permission for my son/daughter to self-administer their medication/treatment if the school nurse determines it is safe. Yes ☐ No ☐**
2. **I give permission for my son/daughter to be photographed by the nurse to ensure safe administration. Yes ☐ No ☐**

**I understand that I may retrieve the medication or child's photo from the school at any time and that the medication and photo will be destroyed if it is not picked up by the last day of school in June.*

**I will notify the school nurse immediately for any changes in this medication/treatment order.*

**I acknowledge that the school nurse may share pertinent health information with appropriate school staff.*

_____ _____
Signature of Parent/Guardian **Date**