Envision the Future

A STEM Program for Girls Ages 11 - 13

A Southeastern Massachusetts STEM Network Initiative in Collaboration with CONNECT

Parent/Guardian Consent for Medication Administration

Student: _____

Date of Birth: _____ **Grade:** _____ **Date of Consent:** _____

My daughter is known to have the following **allergies**:_____

Diagnosis (if not in violation of confidentiality): _____

1. I request and give permission to the school nurse to give my daughter:

Medication:

Dosage: _____

Route: _____

Time of Day: _____

Prescribed by: _____

Medication:

Dosage: _____

Route: _____

Time of Day: _____

Prescribed by: _____

2. I give permission to the program nurse to share with appropriate school personnel information relative to the prescribed medicine administration as s/he determines necessary for my child's health and safety.☐ **Yes**☐**No**

3. I understand that in the event of a field trip, this medication administration plan may need to be adjusted.

4. 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 the termination of the order or the last day of the program.

Parent/Guardian Signature: _____ Date: _____