



Mystic Valley Regional Charter School

770 Salem Street • Malden, MA 02148 • Telephone 781-388-0222 • Facsimile 781-388-0777

PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

Student's Name: _____ Student's Teacher: _____ Grade: _____

Please list your child's allergies: _____

Please list all medication your child is currently taking: _____

Child's Doctor: _____ Phone number: _____

I give permission for the school nurse or school personnel designated by the school nurse to give the following medications:

Name of Medicine: _____ Dose: _____ Time to be given: _____

Starting Date: _____ Ending Date: _____

Check if this medication is to be ordered for the duration of the school year 2008-2009: _____

Name of Medicine: _____ Dose: _____ Time to be given: _____

Starting Date: _____ Ending Date: _____

Check if this medication is to be ordered for the duration of the school year 2008-2009: _____

Name of Medicine: _____ Dose: _____ Time to be given: _____

Starting Date: _____ Ending Date: _____

Check if this medication is to be ordered for the duration of the school year 2008-2009: _____

I give my permission for the school nurse to share, with appropriate school personnel, information relative to the medication administration (e.g., adverse side effects, etc), as she determines necessary for my child's health and safety. Yes _____ No _____

I give permission for school personnel to give the above medicine to my child during school field trips, as needed.

Yes _____ No _____

Signature _____

Date: _____

Relationship to Student _____

PLEASE NOTE: PARENT(S)/GUARDIAN(S) NEED TO BRING IN MEDICATION TO SCHOOL NURSE. THE SCHOOL DOES NOT PROVIDE ANY MEDICATION.