Bedford Public Schools School Year_____

Parent/Guardian Consent for the Administration of Medicine in School

I give permission for the school nurse and her/his designee to administer the following medication:

1. Student's Name_____ Date of Birth_____Teacher_____
2. Name of Medication_____
3. Dose_____
4. Time(s) to be given_____
5. Start Date_____ End Date_____
6. List Child's Allergies_____
7. List other medications the child is currently taking_____
   _____

*****Consent*****

1. I give permission for my child to self-administer the medication if the school nurse determines it is safe and appropriate. Yes___ No___

2. I give the school nurse permission to share with the appropriate school personnel 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 restriction on release_____.

I understand that the school personnel are not responsible for any problem arising from the effects of the medication or for the omission of the medication.

I further agree to indemnify and hold harmless the Town of Bedford and its agents and servants against all claims as a result of any and all claims as a result of any and all acts performed under this authority.

The nurse is not in the school at all times, and there may be reasonable delay in administering the medication.

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

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Signature of Parent/Guardian Date