



2009-2010 Resident Student Medication/Immunization Consent

Student's Full Name: _____ Preferred Name: _____

Birth Date: ____/____/____
mm/dd/yyyy

Grade: _____

Confidential Information:

List any major illness/injury/operation in the past year: _____

Authorization for Medication/Immunization Administration:

I hereby authorize the school nurse to administer or oversee the administration of the following to my student who is named above:

- 1) Over-the-counter medications (**including**, but not limited to, those used for pain, allergies/colds, stomach/intestinal upset, and topical ointments/creams) as specified in written protocol approved by the Ben Lippen physician consultant.
- 2) Prescription medications as prescribed by a physician.
- 3) Any immunizations of which I have not provided documentation that are required by the state of South Carolina for school attendance and any recommended booster immunizations.
- 4) An influenza vaccine as recommended.

Please list any medications you desire **NOT** to be given to your student: _____

Signature of Parent or Legal Guardian: _____

Print Name of Parent or Legal Guardian: _____

Date _____