## Parent / Guardian Authorization For Medication Administration

Student's Name: _____ Date of Birth: _____

Parent / Guardian's printed name: _____

Telephone numbers: Home: _____ Cell: _____
Work: _____

Other person(s) to be notified in case of medication emergency:
Name: _____ Telephone Number: _____

I consent to have the school nurse administer the following medication to my son/daughter:
_____ Dose _____ Time _____
For a period from _____ to _____
The medication is prescribed by: _____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality) _____

My son/daughter has the following food or medication allergies: _____

_____

- ✓ I give permission for my child to self-administer his/her medication, if the school nurse determines it is safe and appropriate. Yes____ No___
- ✓ I give permission for a staff member designated by the school nurse to administer prescribed medication to my child on a field trip. Yes____ No_____

  *I understand that if an EpiPen is administered, my child will be transported to the nearest hospital and I will be called.*
- ✓ I give permission to the school nurse to share information relevant to the prescribed medication as she determines appropriate for my child's safety. Yes_____ No_____

I understand I may retrieve the medication from the school, through the school nurse, at any time; however, the medication will be destroyed if not picked up within one week following termination of the order or one week beyond the close of school.

Parent / Guardian signature: _____ Date: _____

Relationship to the student: _____

*STOUGHTON PUBLIC SCHOOL*
*STOUGHTON, MASSACHUSETTS*

# MEDICATION ORDER

(to be completed by a Licensed Prescriber, Physician,
Nurse Practitioner or others authorized by Chapter 94C)

Name of Student: _____ Date of Birth: _____

Address: _____ Grade: _____
(street) (city/town)

Name of Licensed Prescriber: _____ Title: _____

Business Telephone No.: _____ Emergency Telephone No.: _____

Medication: _____

Route of Administration: _____ Dosage: _____

Frequency: _____ Time(s) of Administration: _____
(Please note: Whenever possible, medication should be scheduled at times other than school hours).

Specific directions or information for administration: _____

Date of Order: _____ Discontinuation Date: _____

*Diagnosis: _____

*Any other medical condition(s): _____

Optional Information:

1. Special side effects, contraindications, or possible adverse reactions to be observed: _____
2. Other medication being taken by the student: _____

   _____
3. The date of the next scheduled visit or when advised to return to prescriber: _____
4. Consent for self administration (provided the school nurse determines it is safe and appropriate). Yes _____ No _____

_____
Signature of Licensed Prescriber