



HEALTHCARE PROVIDER ORDER AND PARENT PERMISSION FORM MEDICATION ADMINISTRATION IN SCHOOL

Your child's HEALTHCARE PROVIDER must fill out this section completely and sign for both prescription and over-the-counter medications:

Student Name _____ Medication Allergies _____

Provider Name _____ Telephone Number _____

Date of Order _____ Length of Order _____

Name of medication _____ Dose _____

Route _____ Time to be given at school _____

Diagnosis (es) _____

Side effects or contraindications _____

May child self-administer if school nurse determines that it is safe and appropriate? Yes / No

Physician's Signature _____

Parent/guardian must fill out this section completely and sign for any medication to be given in school:

Student name _____ Date of birth _____ Homeroom _____

Parent/guardian Name _____ Day Phone _____

Emergency Contact _____ Telephone _____

Name of Medication _____ Exact dose _____

Any food or drug allergies _____

I give permission to the school nurse to: (1) delegate or administer medication as prescribed by my child's healthcare provider, (2) share information relevant to the prescribed medication as she determines appropriate for my child's health and safety, (3) determine if self-administration of medication is safe and appropriate for my child's health.

Parent/guardian signature _____ Date _____

****PLEASE REVIEW SCHOOL MEDICATION POLICY. MEDICATION WILL NOT BE ADMINISTERED IN SCHOOL IF MEDICATION POLICIES ARE NOT OBSERVED. OUR FAX NUMBER IS (617) 325-2260.****