MIDDLEBOROUGH PUBLIC SCHOOLS

AUTHORIZATION FOR MEDICATION ADMINISTRATION

PARENT/GUARDIAN CONSENT:

Student's Name_____ DOB____/____/____

School_____ Grade_____ Homeroom_____

Parent/Guardian Name_____ Parent/Guardian Name_____
Home Telephone_____ Home Telephone_____
Work Telephone_____ Work Telephone_____
Cell Telephone_____ Cell Telephone_____

Other person to be notified in case of emergency:
Name: _____ Telephone Number:_____
Name: _____ Telephone Number:_____

I consent to have the school nurse or trained and designated school personnel administer this medication to my child as prescribed. Yes_____ No _____

I give permission for the school nurse to share information relevant to the prescribed medication administration as determined appropriate for my child's safety. Yes _____ No _____

I give permission for my child to self-administer this medication if the physician and the school nurse determine it is safe and appropriate. Yes _____ No _____

In the event of a field trip the following will occur:
____ The medication may be withheld (not given) on the day of the field trip.
____ The school nurse will designate a trained staff member to administer this medication to my child on the field trip.

Parent/Guardian Signature_____ Date____/____/____

LICENSED PRESCRIBER:

Name of Medication_____ Dose_____
Route_____ Frequency medication to be given_____
Time to be given at school_____Expiration date of med____/____/___
Diagnosis_____
Food/Medication Allergies_____

Allergy Treatment_____

Side effects/adverse reactions to be observed_____

I give permission for the student to self-administer this medication if it is determined to be safe and appropriate. Yes_____ No_____

Licensed PrescriberSignature_____Date____/____/____