Medication Authorization and Plan

All students receiving medication at school require a Medication Authorization and Plan. Prescription and non-prescription medications are permitted at school only when a completed Medication Authorization and Plan is on file. This form is valid for school year 20____to 20____.

Parent Section

I, the undersigned, as legal parent/guardian of _________________________________, attending Holliston Public Schools, Grade _____,

- Give permission to have the School Nurse or school personnel designated by the School Nurse to give the following medicine (name and dose) ____
- Give permission for my son/daughter to self administer medication if the School Nurse determines it is safe and appropriate. Yes ⬜ No ⬜
- Give permission to the School Nurse to share with the appropriate school personnel information relative to the prescribed medication administration, ex. adverse side effects, as she/he determines necessary for my son's/daughter's health and safety. Yes ⬜ No ⬜ Any restrictions _______________
- Understand that daily meds, emergency meds, and inhalers will be sent on Field Trips and administered by designated school personnel. Yes ⬜ No ⬜
- Understand that I may retrieve the medicine from the school at any time and that the medicine will be destroyed if it is not picked up within one week following the termination of the order or the last day of school. Yes ⬜ No ⬜

____

Date **Parent/Guardian Signature**

____

Home Address **Home Phone** **Work Phone**

Provider Section

To be completed by a licensed prescriber: Physician, Nurse Practitioner, or other authorized by Chapter 94C

Name of Student ____ **Date of Birth** ___________________

Allergies:

____

Diagnosis____

Medication____**Dose**___________________________________

Route of Administration ____

Frequency _____________________________________ **Times of Administration** ___________________

Date of Order __________________________________ **Discontinue Date**

____

Special Instructions

____

Consent for self-administration provided the School Nurse determines safe and appropriate Yes⬜ **No** ⬜

Possible Side Effects ____

Printed name of Provider

____

Provider Signature Date Approved By School Nurse

____

(11/2022)