MONOMOY REGIONAL SCHOOLS

MEDICATION AUTHORIZATION FOR PRESCRIPTION MEDICATIONS

School regulations require a written authorization from **both** the physician and parent/guardian for the administration of medication in school. This applies to **both prescription and over-the-counter medications.** Whenever possible, medication should be scheduled at times other than school hours.

PHYSICIAN'S ORDER:

STUDENT NAME:____ Date:______________________

Allergies:____DOB:_______________________

Diagnosis:____

Medication:_____________________________________Dosage:____________Route:____________

Frequency:____Administration Time:___________

Side effect, contraindications, adverse reactions:____

Discontinuation Date:______________________________

Other medications taken by student:____

Consent for self-administration (if school nurse determines it is safe/appropriate):_____yes _____no

Physician Signature:_____________________________________Phone Number:__________________

Physician Name (print):____

PARENT/GUARDIAN AUTHORIZATION FOR ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY:

All prescription and over-the-counter medications must be in the original pharmacy/manufacturer container, clearly labeled with child's name, date, strength and dosage of the medication. **Pharmacies will provide a second labeled container for school, and only a maximum 30 day supply of oral medication may be stored in school.**

Student's Name:____Date:__________________________

Grade:_________________Teacher:____

I give the School Nurse my permission to share with appropriate school personnel information relative to prescribed medication as she/he determines it is necessary for my child's health and safety.:_________yes_________no

Parent/Guardian Signature:____

Home phone:__________________Work Phone:_____________Cell phone:______________________________

Please pick up unused medication at the end of treatment or the end of the school year, or it will be discarded.