Northborough/Southborough/Algonguin Regional Public Schools
HEALTH SERVICES
AUTHORIZATION FOR DISPENSING MEDICATIONS

Name of student: _____ GRADE: _____ Hr: _____

ALLERGIES: _____

TO BE COMPLETED BY PHYSICIAN OR LICENSED PRESCRIBER:

I request my patient receive the following medication:

Student: _____ Diagnosis: _____

Name of medication: _____ Form of medication: _____

Start date: _____ Stop date: _____ Time to be administered: _____

Possible side effects or adverse reactions: _____

The student is both capable and responsible for self-administering this medication. YES NO

Signature of Licensed Prescriber/Physician: _____

Date: _____ Phone: _____

Stamp:

I give permission to have the school nurse to administer the following medication,

_____ prescribed by _____ to my child.

I give permission to the school nurse to share with appropriate school personnel the information relative to the prescribed medication administration, e.g., adverse side effects, etc., as he/she deems necessary for my child's health and safety. **YES NO**

My child is currently receiving the following medications:

1. _____
2. _____
3. _____
4. _____

I request my child receives their medication at school prior to dismissal on early release days. **YES NO**

_____ _____ _____

Parent/Guardian Signature Phone Date