



# DARTMOUTH PUBLIC SCHOOLS

8 Bush Street, Dartmouth, MA 02748

Phone: 508-997-3391 Fax: 508-991-4184 Website: www.dartmouth.school

## AUTHORIZATION FOR DISPENSING MEDICATION (To be completed by Parent/Guardian and returned to school nurse)

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| Cushman Elementary School<br>508-910-1454-Fax          | James M. Quinn Elementary School<br>508-997-6257-Fax | Joseph DeMello Elementary School<br>508-990-2519-Fax |
| George H. Potter Elementary School<br>508-990-0250-Fax | Dartmouth Middle School<br>508-999-7720-Fax          | Dartmouth High School<br>508-961-1620-Fax            |

Student's Name: \_\_\_\_\_ Gender: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian Names: \_\_\_\_\_

Address: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ Work Telephone Number: \_\_\_\_\_

Emergency Contact Person (If Parent/Guardian is unavailable):

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Relationship: \_\_\_\_\_

My child is currently receiving the following medications (to be completed if not in violation of confidentiality). Please list all medication the child is receiving, including those given during the school day: \_\_\_\_\_  
\_\_\_\_\_

My child is known to have the following allergies: \_\_\_\_\_

I give permission to have the school nurse/trained personnel give the following medications: \_\_\_\_\_

Prescribed by: \_\_\_\_\_  
to \_\_\_\_\_ (child's name).

I give permission for my child to self-administer the medication if the school nurse determines that it is safe and appropriate.  Yes  
 No

My child has my permission to self-administer his/her daily medication according to the physician's order/instructions on the day of his/her field trip. My child's teacher or designee will carry the medication until scheduled medication time.  
 Yes  No

My child has my permission to self-administer his/her inhaler according to the physician's order/instructions on the day of his/her field trip. My child's teacher or designee will carry the medication until needed per physician's order.  
 Yes  No

I give permission for the school nurse to delegate to trained unlicensed school personnel to administer epinephrine (by auto-injector) to my child with a diagnosed life-threatening allergic reaction condition when the school nurse (RN) is not immediately available or on field trips.  Yes  No

I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within one week following the expiration of the order or by the last day of the school year. I also understand that the school nurse may share, with appropriate school personnel, information relative to the prescribed medication, e.g., adverse side effects, as he/she determines necessary for my child's health and safety. (If you object to this, please contact the school nurse).

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_