Tahanto Regional Middle-High School
1001 Main Street
Boylston, MA 01505

MEDICATION ADMINISTRATION REQUEST

Student's Name_____Birth Date_____

TO BE COMPLETED BY PHYSICIAN

Medication_____Dose_____Route_____
Time of Administration during school hours _____Side Effects:_____
Specific directions for administration _____
Diagnosis (if not in violations of confidentiality)_____

Consent for self-administration provided physician and school nurse determines it is safe and appropriate: (Circle One) Yes No

Printed Name of MD _____ Phone_____

Signature of MD _____Date_____

TO BE COMPLETED BY PARENT/GUARDIAN

Requirements for medication administration by the school nurse:

a. The school nurse has my permission to administer the above medication as directed by the physician's order. I understand that in the event of a school trip, an unlicensed staff may administer this medication.

b. Medication will be in original pharmacy container properly labeled and delivered to school health office by an adult. **As per school policy, no child will carry/transport medication to and from school.**

c. I understand this consent is good for the current school year only.

d. I give permission for the school nurse to share with appropriate school personnel information relative to the prescribed medication e.g. adverse side effects, as she determines necessary for my child's health and safety.

e. I understand the school nurse will destroy any medication not picked up by the last day of school.

Parent/Guardian Printed Name_____

Parent/Guardian Signature:_____ Date_____