Carlisle Public Schools
Carlisle, Massachusetts

Orders For Medication To Be Administered At School

Name of Patient: _____

Address: _____

Diagnosis: _____
Medication: _____
Dosage: _____
Time of Administration or supervision _____

Exact length of time medication to be administered _____

Date Medication is to begin:_____

Date Medication is to be discontinued: _____

Possible side effects: _____
_____

Return visit recommended in _____ months

Date: _____ _____
Physician's Signature

Address: _____
_____

To be signed by Parent or Guardian
I, the undersigned, give permission to school personnel to administer to or to supervise my child in taking the above medication.

I understand that the school personnel are not responsible for any problem arising from the effects of the medication or the omission of medication.

I further agree to indemnify and hold harmless the Town of Carlisle and its agents and servants against all claims as a result of any and all acts performed under this authority.

_____ _____
Date Signature of Parent or Guardian

**dedicated fax line to Health Office (978) 371-7075*