

# Parent/Guardian Authorization for Medication Administration

Cohasset Public Schools

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Physician Name/Telephone Number: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Frequency: \_\_\_\_\_ Time(s) of Administration: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

I consent to the school nurse or school personnel delegated by the school nurse to administer this medication to my child. I give permission to the school nurse to share information relevant to the medication and diagnosis as he/she determines appropriate for my child's health and safety.

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

**Prescription medication will also require a Healthcare Provider  
Order/Authorization to Administer Medication at School**

All prescription medication must be in the pharmacy container, properly labeled with the student's name, dosage, and the prescribing provider's name. Over-the-counter medication must be in the manufacturer's container and labeled with the student's name.

Medication Receipt Log

Date	Number Received	Parent Initials	Nurse Initials	Date	Number Received	Parent Initials	Nurse Initials