Barnstable Public Schools Medication Authorization

State and school regulations require annual written authorization from **both the physician and parent/guardian** for the administration of medication in school. This applies to **both prescription and over-the-counter medications.**

MEDICATION ORDER

To be completed by a licensed prescriber

Student Name: _____ DOB: _____
Allergies: _____
Diagnosis: _____
Medication: _____ Dosage: _____ Route: _____
Frequency: _____ Administration Time: _____

Please note: Whenever possible, medication should be scheduled at times other than school hours.

Date of Order: _____ Discontinuation date: _____

Side effects, contraindications, adverse reactions: _____
Other medications taken by the student: _____
Date of next scheduled visit: _____
Consent for self-administration (provided the school nurse determines it is safe and appropriate): ____Yes _____ No

Name of Licensed Prescriber: _____ Date: _____
Physician Signature: _____ Phone Number: _____

PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

All prescription and over-the-counter medications must be in the original pharmacy container, labeled with the child's name, the date, and the name, strength, and dosage of the medication. Most pharmacies will provide a second labeled container, if requested. **An adult must bring all medication to school. Only a 30-day supply may be stored in school.**

Student Name: _____ Grade: _____

1. I give permission for the school nurse to administer the above medication ordered by the above prescriber to my child. _____Yes _____ No
2. I give permission for the school nurse to share information relative to prescribed medication administration as she/he determines appropriate for my child's health and safety with appropriate school personnel. _____ Yes _____ No
3. I understand that if my child's class has a field trip that another trained adult (other than the school nurse) may administer the medication to my child. _____ Yes _____ No
4. I give permission for my child to self-administer medication (if the prescriber consents and the school nurse determines it is safe and appropriate). _____ Yes _____ No

Parent/Guardian printed name: _____ Relationship: _____
Parent/Guardian signature: _____ Date: _____
Preferred phone number: _____ Other phone number: _____

At the end of treatment or school year, any unclaimed medication will be discarded.

3/18/22