

Monomoy Regional School District
Parent/Guardian Authorization For Prescription Medication Administration At School

Student's name _____ Date of Birth _____

Medical conditions _____

Allergies _____

Parent/Guardian name _____

Telephone number: Home (_____) _____ Cell (_____) _____

Other person to be notified in case of medication emergency:

Name _____ Telephone number (_____) _____

I request and give permission to the school nurse to give my son/daughter:

Medication:	Dose:
Reason:	Time:
Prescriber name: Prescribers Office:	Route (circle): Oral Inhaled IM Other: _____

By signing below I am acknowledging and providing authorization for the school nurse to do the following:

- I give permission to the school nurse to share information relevant to the prescribed medication administration as they determine appropriate for my child's health and safety.
- I understand that lunchtime medication is not dispensed in school on half days.
- Medications should be delivered to the School Nurse in a pharmacy or manufacturer-labeled container by you or a designated responsible adult. Please ask your pharmacy to provide separate bottles for school and home. No more than a thirty-day supply of the medicine should be delivered to the school.
- I may retrieve the medication from the school at any time. Medication will be destroyed if it is not picked up within one week following termination of the order, upon expiration of the prescription, or by 1pm on the last day of school.
- For field trips or extracurricular/after school activities where the school nurse is not present: the school nurse may delegate medication administration to the student's teacher or other designated school personnel **when appropriate/if applicable.**

I give permission for my son/daughter to self-carry medication and self administer if the school nurse and licensed prescriber determines it is safe and appropriate. _____ Yes _____ No **(please check one)**

Parent/Guardian Signature _____ Date: _____

Relationship to Student _____