CARLISLE PUBLIC SCHOOL
MEDICATION PERMISSION FORM

Massachusetts regulations require a medication order from a licensed prescriber for medications administered by the school. Carlisle Public Schools follows Massachusetts Department of Public Health requirements, including 105 CMR 210.00 when administering any medication, whether it is a prescription drug or over-the-counter medication.

Student Name:_____DOB:_____Grade:_____

To Be Completed by the Licensed Prescriber (Order may be attached to this form)

Please complete this form if the student must take medication during school hours and it cannot be given at home. This order will be valid through the current school year (including the summer school program if the child participates) or unless otherwise noted. Medication orders must be renewed at the beginning of each school year.

Name of Medication:_____ Dose:_____

Frequency:_____Route:_____Time(s):_____

Diagnosis/Medical Condition:_____Known Allergies:_____

Directions for Administration:_____

Side Effects/Reactions to Monitor:_____

Other Medications Taken by Student:_____

Prescriber Name:_____Prescriber Phone:_____

_____

Licensed Prescriber Signature **Date**

To Be Completed by Caregiver

I authorize the school nurse or school personnel designated by the school nurse to administer the medication described above in accordance with the licensed prescriber's order and Carlisle Public Schools procedures.

Yes ▢ No ▢ I authorize my child to self-administer/self-carry this medication when approved by the school nurse and in accordance with the student's individual health plan and school procedures.

_____

Caregiver Signature **Date**

Medication Administration Plan: To Be Completed By the School Nurse

Location of Administration: ▢ Health Office ▢ Other: _____Date Received: _____

Storage Location/ Instructions: _____

Nurse Approved Self-Administration/Self-Carry: ▢ Yes ▢ No ▢ Not applicable ▢ Delegated to: _____

Field Trip/After School Administration Plan:_____

_____

School Nurse Signature **Date**