

Sippican School

16 Spring Street, Marion, Massachusetts 02738 / (508) 748-0100
FAX (508) 748-1953

**Sample Parent/Guardian Authorization
For Prescription Medication Administration**

Student's name _____

Parent/Guardian printed name _____

Telephone number—Home: _____ Cell Phone number _____

Telephone number—Work: _____

Telephone number—Emergency: _____

Other person(s) to be notified in case of medication emergency:

Name: _____ Telephone number: _____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

My son/daughter has the following food or drug allergies:

I consent to have the school nurse or school personnel designated by the School Nurse administer the medication prescribed by:

_____ to _____
Licensed Prescriber Student's Name

I give permission for my son/daughter to self-administer medication, if the school nurse determines it is safe and appropriate.

____ Yes ____ No

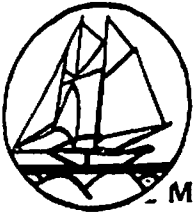
I give permission to the School Nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Parent/guardian signature _____

Relationship to Student _____

Address: _____



Medication Order Form to be completed by a licensed prescriber

Name of Student _____ Date of Birth _____

Address _____ Grade _____
(street) (city/town)

Name of Licensed Prescriber _____ Title _____

Business Telephone Number _____

Emergency Telephone Number _____

Medication _____

Route of administration _____ Dosage _____

Frequency _____ Time(s) of Administration _____

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

Specific directions or information for administration: _____

Date of Order _____ Discontinuation Date _____

Diagnosis* _____

Any other medical condition(s)* _____

Optional Information

1. Special side effects, contraindications, or possible adverse reactions to be observed: _____

2. Other medication being taken by the student: _____

3. The date of the next scheduled visit or when advised to return to prescriber: _____

4. Consent for self administration (provided the school nurse determines it is safe and appropriate).

Yes _____ No _____

Signature of Licensed Prescriber

Date: _____

* if not in violation of confidentiality.