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:_____

Sippican School

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

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.