Shawsheen Valley Technical High School, 100 Cook Street, Billerica, MA 01821

Parent/Guardian Authorization for Prescription Medication Administration

Student's Name _____ Date of Birth_____

Parent/Guardian printed name _____

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 (please see Field Trip Policy) administer the medication prescribed by:

_____ to _____

Licensed Prescriber (M.D.) Student's Name

I give my 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/daughter's health and safety. _____ Yes _____ No

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 _____ Date_____

Relationship to student _____

Any prescription medications to be administered during school must have the accompanying Medication Order Form Completed and submitted to the **Nurses Office**

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Medication Order Form [to be completed by a licensed prescriber (M.D.)]

Name of student _____ Date of birth _____

Parent/Guardian Name: _____

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 (if not in violation of confidentiality) _____

Any other medical condition(s) (if not in violation of confidentiality) _____

Name of licensed prescriber _____ Title _____

Business telephone number _____

Emergency telephone number _____

Optional Information

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

_____

2. Other medication being taken by the student _____

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

4. Consent for self administration Yes ____No _____ *(appropriateness may be evaluated by school nurse)*

_____ _____
Signature of Licensed Prescriber Date