

**DEDHAM PUBLIC SCHOOLS
SCHOOL HEALTH SERVICES**

AUTHORIZATION FOR MEDICATION ADMINISTRATION

***This form must be completed BEFORE any medication (over the counter or prescription) can be administered.**

PRESCRIBER ORDER

Name of student _____ **DOB** _____

Diagnosis _____

Name of medication _____

Dosage _____ Route of administration _____

Frequency _____ Time(s) of administration _____

Specific directions or information for administration _____

Date of order _____ Discontinuation date _____

Name of licensed prescriber _____ Phone# _____

Signature of licensed prescriber _____

SIGNED PARENT / GUARDIAN CONSENT

My child is currently receiving the following medication(s) _____

My child has the following known allergies _____

I consent to have the school nurse or school personnel designated by the school nurse administer the medication prescribed by _____ for my child _____

I understand that 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. **Medication must be provided in the original pharmacy or manufacturer-labeled container.** Please ask your pharmacist to provide separate bottles for school and home. Only the doses to be given during school hours should be brought to school. At most, a 30-day supply of the medication can be stored at the school. Medication must be delivered by the parent/guardian or another responsible adult designated by the parent / guardian. **Students may not carry medication in school.**

Parent / Guardian signature _____ **Date** _____ **Relationship to student** _____

If you have any questions, please call the nurse at your child's school

Thank you very much.