MARLBOROUGH PUBLIC SCHOOLS
Health Services
Marlborough, MA 01752

MEDICATION ADMINISTRATION AND PERMISSION FORM

Student Name: __________________________________ Date of Birth _____________ Grade _____ School _________________
Parent/Guardian: ________________________________ Home # _______________________ Work # _____________________
Emergency Contact _____________________________ Phone ____________________
Licensed Prescriber ______________________________________ Address ____
Office # ____________________________________ Emergency # ____

Diagnosis: ____________________________________ **Food/Drug Allergies** ____

Medication Order

Name of Medication ___________________________ Dosage ________ Route ______ Times to be given __________
Specific Instructions ____
Possible Side Effects/ Adverse Reactions ____
Location for Administration ______ Health Room ______ Other (Specify) __________________________________
Date Ordered _____________________ Duration of Order ______________________________
Any Other Medical Conditions ____

Licensed Prescriber Signature ____ Date ___________________________

Consent: I give my permission to the school nurse or school personnel designated by the school nurse to give the prescribed medication above. YES _______ NO _______

Consent: I give my permission for my son/daughter to self administer medication if the school nurse determines it is safe and Appropriate. YES _______ NO _______

Consent: I give my permission to the school nurse to share with appropriate school personnel information relative to the Prescribed medication administration, e.g. adverse side effects, as she/he determines necessary for my son's/daughter's health and safety. YES _______ NO _______

Consent: I give my permission to the school nurse to delegate medication administration to selected school personnel in the **event of a field trip.** YES _______ NO _______

Please Note: I understand that I may retrieve the medication from the school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order.

Parent Signature ____ Date ___________________________

School Nurse Signature ____ Date ____________________________

Student Signature (if appropriate) ____ Date ____________________________