Arlington Catholic Physician Medication Permission Form

This form is to be completed by physician and parent before any medication (over the counter or prescription drug) can be dispensed in school. (M.G.L. Chapter 112 § 80)

Student Name _____ **D.O.B**. _____

Physician/Practitioner:
Please complete if any Prescribed or Over the Counter medication is needed by the student during school hours.

Medication _____Dosage_____ Route _____

Frequency _____ Times To Be Given _____

Special Instructions _____

Date of Order _____ Discontinuation Date _____

Diagnosis _____ Drug/Food Allergies_____

Name of licensed Prescriber _____Title _____
(print)

Signature of Licensed Prescriber_____ **Date** _____

Address _____ Phone _____

Name of Parent/Guardian_____ Relationship _____
(print)

I the undersigned parent or guardian, give permission to the school nurse (or school personnel delegated by the school nurse) to administer the above medication to my child. I authorize the nurse to share information about the medication administration as the school nurse deems necessary for the health and safety of my child.

Signature of Parent / Guardian _____ Date _____

Telephone
Home _____Work _____ Cell/Pager _____