Milton Community Schools

A self-supporting Department of Milton Public Schools

https://www.miltonps.org/departments/community-schools

Authorization for Prescription Medication Administration

In order for a medication plan(prescription and non-prescription), and/or treatment plan to be given to your child during any Milton Community Schools program, this form needs to be completed by both you and your child's doctor or clinic. (Please note: nurses are currently not on staff at our programs.) Return the completed form to your child's program staff. Printed attachments from your health care provider can be attached to this form. An original signature from your health care provider is required below.

Student Name:_____ **Date of Birth**_____ MCS **Program**_____

MEDICAL PROVIDER INFORMATION

Treatment Plan/Care Plan

Description Medical condition(s)*/Allergies _____

Special healthcare and/or treatments necessary while child is in program_____

Potential side effects of treatment and consequences if the treatment isn't administered_____

Special Instructions to specific activities on-site and/or off-site_____

Medication Plan

Medication_____ Route of Administration_____

Dosage_____ Frequency_____

Time(s) of Administration_____ Date of Order_____ End date_____

Specific directions or information for medication plan _____

Other medication Information: (side effects, contraindications, or possible adverse reactions; other medications being taken, specific directions for storage) _____

_____	_____	_____
Signature of Licensed Prescriber	Please Print Name Name of Practice Group	Business Telephone Number

PARENT/GUARDIAN INFORMATION AND CONSENT

Parent/Guardian Name_____

Tel # (Cell)_____

(Work)_____

Parent/Guardian Name_____

Tel # (Cell)_____

(Work)_____

Other person(s) to be notified in case of medication emergency:

Name:_____Relationship_____ Telephone number:_____

Name:_____Relationship_____ Telephone number:_____

I give permission to have MCS trained staff administer this medication and/or treatment/care plan	____Yes ____No (Please Initial)
I give permission to MCS staff to share information relevant to the prescribed medication and/or treatment/care plan as s/he determines appropriate for my child's health and safety.	____Yes ____No (Please Initial)
I give permission to the program staff to photograph my child, to keep on file for identification purposes only and/or to provide the program with my child's picture if needed.	____Yes ____No (Please Initial)
I understand I may retrieve the medication from the program at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order.	____Yes ____No (Please Initial)
I understand the 1st dose of any medication must be given by the Parent/Guardian unless it's an epi-pen.	____Yes ____No (Please Initial)

_____	_____
Parent/Guardian Signature	Date