MILTON PUBLIC SCHOOLS

HEALTH SERVICES
Authorization for Prescription Medication Administration

Student Name: _____ Date of Birth: _____

Parent/Guardian _____

Telephone # home _____
Telephone # work _____
Telephone # – Emergency contact _____

Name and telephone of other person to be notified in case of medication emergency_____

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 administer the medication prescribed by:

_____ to _____
Licensed Prescriber Student's Name

I give 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 child's health and safety. 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 the termination of the order or one week beyond the close of school.

Signature: _____Date: _____
Parent/Guardian

MILTON PUBLIC SCHOOLS

HEALTH SERVICES

MEDICATION PRESCRIPTION FORM
(To be completed by a licensed prescriber)

Name of student: _____ Date of birth: _____

Address: _____ Grade: _____

Name of Licensed Prescriber: _____ Title:_____

Business telephone: _____

Emergency telephone: _____

Medication: _____ Dosage: _____

Route of Administration: _____ Frequency: _____ Time(s): _____
(Please note: whenever possible medication should be scheduled at times other than school hours)

Specific directions or information for administration:
_____

Diagnosis:_____

Any other medical considerations: _____

Side effects, contraindications or adverse reactions to be observed: _____
_____

Other medication being taken by this student:_____

Date of next scheduled visit: _____

Consent to self-administer: Yes: _____ No: _____

Signature of Licensed Prescriber: _____

Date: _____