Southwick-Tolland-Granville Regional School District

Medication Authorization Form

STUDENT'S NAME:_____ DATE OF BIRTH:_____

ALLERGIES:_____

SCHOOL:_____ GRADE:_____

LIST ALL MEDICATIONS STUDENT IS CURRENTLY TAKING:_____

_____

CAN STUDENT SELF-ADMINISTER IF DEEMED APPROPRIATE BY THE NURSE? _____YES _____NO

SELF-ADMINISTRATION PLAN:_____

HALF DAY/EARLY RELEASE PLAN: _____

FIELD TRIP PLAN/DELEGATION:_____

I request the above named child be administered the medication listed below as authorized by myself and the prescribing provider below. I understand that I may retrieve the medication at any time and the medication will be destroyed if not picked up by the end of the day on the last day of school.

PARENT/LEGAL GUARDIAN NAME:_____

SIGNATURE PARENT/LEGAL GUARDIAN:_____ DATE:_____

RELATIONSHIP TO STUDENT:_____ PHONE: _____

The following to be completed by the licensed prescriber as authorized by Chapter 94C: Whenever possible, medications will be scheduled outside school hours.

MEDICATION:_____ DOSE:_____ ROUTE:_____ TIME:_____

DIAGNOSIS FOR MEDICATION GIVEN:_____

SIGNIFICANT SIDE EFFECTS:_____

MONITORING REQUIRED FOR SIDE EFFECTS:_____

START DATE:_____ DISCONTINUE DATE:_____

CAN STUDENT SELF-ADMINISTER?: _____YES _____NO

OTHER INFORMATION:_____

NAME OF LICENSED PRESCRIBER:_____

SIGNATURE OF PRESCRIBER:_____ DATE:_____

OFFICE PHONE NUMBER:_____