# BRAINTREE PUBLIC SCHOOLS
# HEALTH SERVICES DEPARTMENT

### PARENTAL AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AND MEDICATION ADMINISTRATION PLAN

Student's Name:_____ Grade:_____ DOB:_____

Parent/Guardian Printed Name:_____

Home Phone:_____ Work #_____ Cell #_____

Physician's Name:_____ Phone number:_____

In case of emergency, please contact: (include name, relationship to student and phone number):

1. _____
2. _____

My child is known to have the following allergies:_____

My child's diagnosis:_____

**All current medications taken at home:** (if not in violation of confidentiality)

| Name of Medication | Dosage | Time(s) | Name of Medication | Dosage | Time(s) |
|---|---|---|---|---|---|
| | | | | | |
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**Medications to be given at school -following is to be completed with the school nurse:**

| Amount Received | Name of Medication/Strength/ Expiration Date | Dosage | Frequency | Time | Route | Side Effects- | Plan for Monitoring Medication/Storage of Medication | Order Date | Order End Date |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
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*****Please complete back side of form**

| **Parent/Guardian Consent:** | **Yes** | **No** |
|---|---|---|
| I give permission for the School Nurse or school personnel designated by the school nurse to give the named student the above listed medication(s) in school or on field trip(s).<br><br>Name of designee to be determined at time of field trip and available upon request. | ☐ | ☐ |
| I give permission to the School Nurse to **share** with appropriate school personnel information relative to the prescribed administration; e.g., adverse side effects, as the nurse determines necessary for my child's health and safety. | ☐ | ☐ |
| I give permission for my child to carry medication, insulin, inhaler or epi-pen **if the School Nurse determines it is safe and appropriate.** | ☐ | ☐ |
| I give permission for my child to self-administer medication, insulin, inhaler or epi-pen **if the School Nurse determines it is safe and appropriate.** *(see attached self-administration plan)* | ☐ | ☐ |

Your signature below indicates that you have read, understand, and agree to the above information.

I understand that the medication may be retrieved from the school nurse at any time; however, the medication will be destroyed if it is not picked up within one day beyond the end of the school year.

Parent/Guardian Signature:_____ Date:_____

School Nurse Signature:_____ Date:_____