Sandwich Public Schools Medication Authorization

School regulations require a written authorization from **both** the physician and parent/guardian for the administration of medication in school. This applies to **both prescription and over-the-counter medications.** Whenever possible, medication should be scheduled at times other than school hours.

PHYSICIAN'S ORDER:

Student Name: _____ Date: _____
Allergies: _____ DOB: _____
Diagnosis: _____
Medication: _____ Dosage: _____ Route: _____
Frequency: _____ Administration Time: _____
Side effect, contraindications, adverse reactions: _____
Discontinuation date: _____
Other medications taken by the student: _____
Consent for self-administration (if school nurse determines it is safe and appropriate):____Yes _____No
Physician Signature: _____Phone Number: _____
Physician Name (print): _____

PARENT/GUARDIAN AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATION DURING THE SCHOOL DAY:

All prescription and over-the-counter medications must be in the original pharmacy container, clearly labeled with the child's name, the date, and the name, strength, and dosage of the medication. **Most pharmacies will provide a second labeled container,** if requested. **An <u>adult</u> must bring all medication to school, and only a 30-day supply may be stored in school.**

Student's Name: _____ Date: _____

I give my permission to the school nurse to administer the above medication ordered by our physician to my child. _____Yes _____No

I give the school nurse my permission to share with appropriate school personnel information relative to prescribed medication as she/he determines necessary for my child's health and safety.____Yes ____No

Parent/Guardian Signature: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____
Grade: _____ Teacher: _____

AT THE END OF TREATMENT OR SCHOOL YEAR, ANY UNCLAIMED MEDICATION WILL BE DISCARDED.