

WESTBOROUGH PUBLIC SCHOOLS

MEDICATION ADMINISTRATION AUTHORIZATION/AGREEMENT
For Prescription AND Over-the-Counter Medications

Student _____ D.O.B. _____ Grade _____

----- TO BE COMPLETED BY LICENSED MEDICAL PRESCRIBER -----

Medication _____ Dose/Route _____ Time _____ Interval _____

Tablet/capsule Liquid Inhaler Injection Nebulizer Other _____

Diagnosis for which medication is prescribed: _____

Start date: _____ Discontinuation date: _____

Significant side effects, precautions: None anticipated Yes - describe: _____

Other medications taken by student: _____

Other medical conditions: _____

The student may self-administer this medication: | No Yes, supervised Yes, unsupervised
(No student may carry or self-administer any psychotropic or controlled medication.)

Printed name of Licensed Prescriber _____ Signature _____

Address _____ Phone _____ Date _____

----- TO BE COMPLETED BY PARENT/GUARDIAN -----

I request that the above medication be administered to my child as prescribed, by a school nurse or her designee. I will bring the medication in the original, properly dated and labeled container, will keep a dosage count at home, and will deliver refills as needed. I will promptly pick up any unused medication.

Permission to share this information with appropriate school staff: | Yes No

Parent/Guardian Signature _____ Daytime Phone _____ Date _____

----- TO BE COMPLETED BY STUDENT -----

I agree to be responsible for coming to the nurse's office at the scheduled time to take my medication.

Student signature _____ Date _____

Disposition of medication: Finished Returned to parent/guardian Disposed - Witness: _____

Nurse Signature: _____ Date: _____

