WESTBOROUGH PUBLIC SCHOOLS

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

Student_____ D.O.B._____ Grade _____

- - - - - - - - - - - - ***TO BE COMPLED 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