SOUTH SHORE CHARTER PUBLIC SCHOOL

Inspiring every student to excel in academics, service, and life

AUTHORIZATION FOR THE ADMINISTRATION
OF PRESCRIPTION MEDICINES BY SCHOOL PERSONNEL

The South Shore Charter Public School requires a licensed prescriber's written order and a parent/guardian's authorization for any medication to be administered during school hours.

PHYSICIAN ORDER*:*

Name of Student_______________________________________ DOB__________ Grade___

Condition for which medication is being administered ____

Medication____ Route of Administration ____

Dosage _________________ Time(s) of Administration ___________ Frequency_____

Date of order: ___________________ Discontinuation date: ______________________

Side effects, contraindications, or possible adverse reactions:
____

Note: Student in grades 5-12 may self-administer inhaler medications with permission of prescriber, parent, and school nurse.
Prescriber permission for student to self-carry and administer inhalers only ____ Yes ____ No

____________________________________ ______________________________________
Name of Licensed Prescriber Signature of Licensed Prescriber

Address ___________________________________Phone #______________________________

Parent/Guardian Authorization

To: South Shore Charter Public School Date_____________

I hereby request and authorize South Shore Charter School personnel to administer the above medication(s) to my child, ______________________________, as ordered above by the licensed prescriber.

My child has the following food or drug allergies:
____

My child is currently receiving the following medications: (please list all)
____

I give permission for _______________________ to self-carry and administer inhalers only ____ Yes ____ No

_____________________________________ _______________________________________
Name of Parent/Guardian Parent/Guardian Signature

Telephone #__________________ Email ____________________________________