

HOPKINTON PUBLIC SCHOOLS

AUTHORIZATION FOR DISPENSING MEDICATION

NAME OF STUDENT: \_\_\_\_\_ GRADE \_\_\_\_\_ H.R. \_\_\_\_\_

1. I give permission to have the school nurse give the following medicine \_\_\_\_\_  
prescribed by \_\_\_\_\_ to \_\_\_\_\_.  
licensed prescriber name of student

2. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medicine administration. YES \_\_\_\_\_ NO \_\_\_\_\_

Any restrictions on release \_\_\_\_\_

3. My child is currently receiving the following medications: 1. \_\_\_\_\_  
2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

4. Known allergies to food or medication: \_\_\_\_\_

5. I request that my child receive his/her medication at school prior to dismissal on early release days: YES \_\_\_\_\_ NO \_\_\_\_\_

NOTE: WHENEVER POSSIBLE MEDICATION SHOULD BE GIVEN AT HOME AND EVERY EFFORT MADE TO AVOID SCHOOL HOURS.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

Physician/Licensed Prescriber:

I request that my patient receive the following medication:

Student Name: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Name of Medication \_\_\_\_\_

Prescribed dosage and route of administration: \_\_\_\_\_

Time to be taken during school hours: \_\_\_\_\_

Expected duration of treatment: \_\_\_\_\_

Possible side effects/adverse reactions: \_\_\_\_\_

Any other conditions requiring medication: \_\_\_\_\_

Other recommendations: \_\_\_\_\_

PHYSICIAN'S/LICENSED PRESCRIBER'S SIGNATURE \_\_\_\_\_

Phone \_\_\_\_\_

DATE: \_\_\_\_\_