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: _____