Northampton Public Schools
Medication Authorization Form

TO BE COMPLETED BY A LICENSED PRESCRIBER:

Student's Name____DOB______________

Diagnosis____Grade_____________

Medication:____

Route of Administration:______________________________Dosage: _______________________

Frequency:____________________Time(s) of Administration_____________________________

Date of Order__________________Discontinuation Date________________________________

Possible side effects/adverse reactions to watch for___________________________________

Other medications being taken by student____

Any other medical conditions (if not in violation of confidentiality)_______________________

Consent for self-administration: YES NO

Name of Licensed Prescriber:______________________________________Title:______________

Business Phone Number__________________Emergency Phone Number_____________________

Signature of Licensed Prescriber:____

TO BE COMPLETED BY PARENT/GUARDIAN:

I authorize the School Nurse or designee to give the above named medication to my child.

Student's Name____Grade___________________

Signature of parent/guardian_____________________________________Date___________________

EMERGENCY CONTACT__________________________________PHONE #_________________

List of other medications____

I give permission for my child to self-administer medication if the school nurse determines it is safe and appropriate.

YES NO

I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medicine administration, IE: adverse side effects, as she/he determines it necessary for my child's health and safety.

YES NO

Any restrictions on release?____

I understand that I may retrieve the medicine from the school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order, or by the last day of school.

Parent/Guardian Signature____________________________________Date___________________