



Trustees:
Les McMullen
Michael Costa
Helen Ciaramella
Jim Carroll
Terri Quigley

Jason Provence
Superintendent

SCHOOL MEDICATION AUTHORIZATION FORM

School of Enrollment:

- Anderson Middle School – Fax: 378-7061
- Anderson Heights – Fax: 378-7051
- Meadow Lane – Fax: 378-7031
- Community Day School – Fax: 378-7051

PHYSICIAN'S ORDER (To be completed by physician only)

Name of child: _____ DOB _____

Name of medication/strength: _____

Dosage: _____ How often? _____

Time to be given at school: _____ Dose form: _____

Reason for medication: _____

Possible side effects: _____

Length of time medication will be necessary: _____

Student has been instructed by physician in the use of inhaler and may carry medication with them.

Student has been instructed by physician in the use of the EPI-PEN and may carry medication with them.

Comments: _____

The pupil for whom this medication is prescribed is under my care.

Print Name of Licensed Physician

Signature of Licensed Physician

Address of Physician

Phone _____ Date _____

TO BE COMPLETED BY PARENT:

I request that my child, _____, be assisted in taking the above prescribed medication at school by authorized persons. I will comply with the school's policies and procedures. I also authorize the school nurse to communicate with the Authorized Health Care Provider when necessary. I understand that I will be provided a copy of my child's completed Individual School Healthcare Plan (ISHP).

Parent Signature

Phone _____ Date _____

Address

Emergency Phone