

Foxborough Regional Charter School
Physician Medication Authorization Form

Health Services:
508-543-2508 ext 360 or 361
Fax: 508-543-5314

Student Name _____ DOB: _____

Prescription Medication

Date of order: _____ Discontinuation Date: _____

Diagnosis* _____

Any other medical conditions* _____

Name of Medication: _____ Dosage: _____

Frequency/ Time: _____ Route of Administration: _____

Side effects, contraindications, possible adverse reactions: _____

Other medications taken by student: _____

Consent for self administration (*provided school nurse determines it is safe and appropriate*)

Yes _____ No _____

Name of Licensed Prescriber; _____ Date: _____

Signature: _____

Telephone Number: _____ Fax: _____

Non-Prescription Medication

Date of Order: _____

Acetaminophen/ Tylenol Dosage _____ Frequency _____ Route of Administration _____

Ibuprofen/ Motrin/ Advil Dosage _____ Frequency _____ Route of Administration _____

Robitussin: Dosage _____ Frequency _____ Route of Administration _____

Other: _____ Dosage _____ Frequency _____ Route of Administration _____

Name of Licensed Prescriber: _____ Date: _____

Signature: _____

Telephone Number: _____ Fax: _____