Major Edwards Elementary School
508-835-4461, Ext. 2162
Fax: 508-835-4119

West Boylston Middle/High School
508-835-4475, Ext. 1135
Fax: 508-835-6075

West Boylston Public Schools

125 Crescent Street
West Boylston, Massachusetts 01583

PARENT/GUARDIAN AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION/NON-PRESCRIPTION MEDICATION

Dear Parent/Guardian:

The West Boylston Public Schools, in compliance with State Law, require the physician and the parents/guardians to complete the following form in order for medication to be administered during school. The medication must e in the original labeled container. Please note that permission must be given for ANY MEDICATION, whether prescription or over-the-counter.

Student Name _____Grade _____

Parent/Guardian (print) _____ Home Phone _____

Work Phone _____ Cell Phone _____

Emergency Contact _____ Phone _____

I give the school nurse permission to administer the following medications during the school day:

Name of Medication	Dose	Time

My child is currently receiving the following medications: *(complete, if not in violation of confidentiality)*

1.	**3.**
2.	**4.**

I give permission for the school nurse to share information relevant to the above, as she determines appropriate for my child's health/safety. _____ *(please initial)*

Parent Signature _____ Date _____

Relationship to student _____

Parent/guardian may retrieve the medication at any time; however, the medication will be destroyed if it is not picked up within one week following the termination of the order or one week beyond the close of school.

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LICENSED PRESCRIBER AUTHORIZATION FOR MEDICATION ADMINISTRATION

Dear Physician:

The West Boylston Public Schools, in compliance with State Law, require the physician and the parents/guardians to complete the following form in order for medication to be administered during school. The medication must e in the original labeled container. Please note that permission must be given for ANY MEDICATION, whether prescription or over-the-counter.

Student's Name _____ DOB _____

Address _____ Grade _____

Medication Instructions

Medication Name:		**Route of Admin:**
Dosage:	**Frequency:**	**Time of Admin:**
Date of Order:	**Discontinuation Date:**	**Diagnosis:**
Other Medical Conditions:		

(Please note: Whenever possible, medication should be scheduled at times OTHER than school hours)

Medication Instructions

Medication Name:		**Route of Admin:**
Dosage:	**Frequency:**	**Time of Admin:**
Date of Order:	**Discontinuation Date:**	**Diagnosis:**
Other Medical Conditions:		

(Please note: Whenever possible, medication should be scheduled at times OTHER than school hours)

Optional Information:

Side effects, contradictions, possible adverse reactions: _____

Other medication being taken by student: _____

Consent for self-administration (provided school nurse determines it is safe/appropriate) _____

Date of next scheduled visit or when advised to return to prescriber _____

Signature of Licensed Prescriber: _____

Print Name _____ ***Phone:*** _____

PARENT/GUARDIAN MUST COMPLETE REVERSE SIDE