Ponaganset High School
Medication Authorization
School Year 2016 - 2017

Student Name: _____ **Grade:** _____ **DOB:**_____

Address : _____ **Phone :** _____

I understand that special permission is required for the use of medication by students during school hours and that the School Nurse is authorized to consult with the prescribing physician / licensed practitioner on matters relating to this order. I request that my child be given the medications described below or be permitted to self-carry/self-medicate as authorized by me and my physician / licensed practitioner. I understand that the school nurse is not present on field trips and that I must execute a form regarding administering medication of field trips. My signature indicates my understanding of these facts, district policy, my responsibility to ensure my child receives any necessary medication, and authorization to administer medications to my child as described below and in emergency situations.

I give permission for TYLENOL 325 mg - 650 mg. to be given to my child on an as needed basis YES : ___ NO:___

_____ _____

Parent/guardian signature **Date**

This section to be completed by Physician / Licensed Practitioner

Diagnosis: _____

Medication(s):_____ **PRN:** _____

Dose: _____ **Route:** _____ **Time:** _____ **Frequency:** _____

May it be repeated: _____ **Start Date:**_____ **End Date:**_____

Describe indications: _____

Side Effects :_____

_____

Allergies: _____ **Special Instructions :** _____

If **EPIPEN** or **INHALER** student may self-administer	Yes_____	No_____
If **EPIPEN** or **INHALER** student may self-carry	Yes_____	No_____
If on a field trip medication may be self-administered	Yes_____	No_____
If on a field trip medication may be delayed until child returns home	Yes_____	No_____
Student must self-carry / self administer the medication	Yes_____	No_____

Physician Signature : _____ **Date:** _____

Please Fax Form To : Kathy Marchetti R.N. Certified School Nurse Teacher @ 764 - 5813