CONCORD PUBLIC SCHOOLS
CONCORD CARLISLE REGIONAL SCHOOL DISTRICT

THIS FORM IS TO BE COMPLETED BY PHYSICIAN AND PARENT FOR ANY MEDICATION TO BE ADMINISTERED IN SCHOOL

Under Massachusetts General Laws (MGL) Chapter 112, Section 80B, a licensed nurse must have a medication order from a physician's assistant in order to administer any medication, whether it is a prescription drug or over-the-counter medication.

Physician:

Please complete this form on bellowed named student for prescribed medication that must be administered during school hours, more than three times a day, and cannot be given only at home.

Student's Name_____ D.O.B._____Grade_____

Diagnosis_____

Food and/or drug allergies_____

Medication prescribed_____

Dosage prescribed_____Route prescribed_____

Frequncy_____Time(s) during day to be given_____

Potential side effects_____

Discontinuation date_____

Other medication currently taking_____

Consent for self –administration (if the School Nurse determines it is safe and appropriate) Yes___No__

_____ _____ _____
Physician's signature Date Telephone number

Parent or Guardian:

I, the undersigned, give permission to the School Nurse/Designee to administer the above named medication to my child.

I give permission for my son/daughter to self-administer the above medication if the School Nurse determines it is safe and appropriate.
Yes___ No___

I understand I may retrieve the medication from the school at any time, however the medication will be destroyed if it is not picked up within one week following termination of the order or at the close of school.

_____ _____ _____
Parent/Guardian Signature Date Telephone number(s)