MILLINOCKET SCHOOL DEPARTMENT

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

Student: _____ Date of Birth: _____
Teacher: _____ Grade: _____

If it is necessary for your child to take medication at school, please complete and sign this permission form. Medications must be brought in by a parent/guardian in the original container with an expiration date and prescription label (if applicable). If a medication is to be given for 15 or more consecutive days, a written order must be obtained from the prescribing provider (please see below).

Medication: _____ Dose: _____
Time/Frequency: _____ Form: _____
Length of Treatment: _____
Reason for Medication: _____
Possible Side Effects: _____

I give my permission for school personnel to administer the above medication to the above named student. To ensure the safety of my child, I understand that medication information may be shared with appropriate school staff if needed.

Parent/Guardian Signature: _____ Date: _____

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Medication Removal:
At the end of the school year or the last day of the student's enrollment, I choose the following method of medication disposal:
_____ Parent/Guardian will remove the medication from school
_____ School Nurse may dispose of the medication

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A written order must be obtained from the prescribing Provider if a medication is to be given 15 or more consecutive days. The following section is to be completed by the PROVIDER.

Medication: _____ Dose: _____
Time/Frequency: _____ Form: _____
Length of Treatment: _____
Reason for Medication: _____
Possible Side Effects: _____
Comments/Recommendations: _____
_____

Provider's Signature: _____ Date: _____

Provider's Name: _____ Phone #: _____

Adopted: 2-12-19