PORTSMOUTH SCHOOL DEPARTMENT
Portsmouth, Rhode Island
Medication Policy - Long Term

Students who require medication on a long term basis (more than 2 weeks) must have this form signed by a parent/guardian and completed by their physician.

I authorize the Portsmouth School Department to administer the following medication per the physician instructions

I authorize the physician and school nurse /teacher to consult regarding this medication/diagnosis.

_____ _____

School Signature of parent/guardian

_____ _____

Teacher and grade Date

_____

Telephone number

Doctor's Orders

Name of the Patient _____

Name of the Medication _____

Amount of Medication _____

Time of the Medication _____ Duration of Medication

Side effects _____ Diagnosis _____

The original prescription bottle must accompany medication and this medication form is to be renewed on an annual basis.

____ May self administer medication on school sponsored field trips

____ May omit medication on school sponsored field trips.

_____ _____

Date Physician Signature