Jennifer Carlson RN
Nichole Collins RN
Madeline Crowell RN

Tammy Lafreniere RN
Melissa McDonald RN
Sue Mungovan RN

MEDICATION AUTHORIZATION FORM

Student Name _____ Date of Birth _____

School _____ Grade _____ Teacher/Cluster _____

This Section to be Completed by Your Child's Physician

Please give the medication prescribed by me as follows:

Medication: _____ Daily: _____ PRN: _____

Dosage in School: _____ Route: _____ Time: _____ Frequency: _____

Describe Indications/Diagnosis: _____ Side Effects: _____

Other Instructions: _____

INHALERS - May self-carry and/or self-administer: Yes: _____ No: _____ MD Initials: _____

Physician Signature *Physician Name (print)* *Date*

This Section to be Completed by Parent/Guardian

I give permission to the Barrington School Department to have my child _____ take the above medication during school hours.

Medication will be supplied by me in the original labeled prescription container or the original over-the-counter packaging. All medication will be labeled with my child's name, name of medication, dosage and time to be given. At the end of the school year, parents/guardians are responsible for picking up any unused medications from the health office or they will be disposed of.

FIELD TRIPS: I understand that if it is necessary for my child to take medication on a field trip away from school, I will provide one school day's supply of the medication in the original bottle for my child to self-carry and self-administer with supervision.

Parent/Guardian Signature *Date* *Best Contact Number*

Revised 08/2022