MEDFIELD PUBLIC SCHOOLS
MEDICATION AUTHORIZATION AND PLAN

All students receiving medication at school require a Medication Authorization and Plan. Prescription and non-prescription medications are permitted at school only when a completed Medication Authorization and Plan is on file. If any of the conditions of this authorization change, a new form must be completed and signed by the parent and health provider.
This form is valid for school year 20____ to 20____.

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PARENT SECTION

I, the undersigned, as legal parent/ guardian of_____(student's name)_____(DOB), attending _____School, Grade_____, request that the following medication(s) be administered to my child as prescribed on this Authorization and in accordance with Medfield School Committee Policy and Massachusetts law. I also authorize, as needed, the sharing of information related to my child's health between the school nurse and the health care provider listed below. I will comply with the procedure provided related to dispensing medication at school.

_____ _____ _____
Date **Parent/ Guardian Signature** **Student Signature (if self-medication is approved)**

_____ _____
Home Address **Home Phone** **Work Phone**

Field Trip Plan for medication (Medications that are not taken daily will be decided on an individual basis):
Medication for elementary school students will be carried by teachers unless otherwise specified.

_____

_____

HEALTH PROVIDER SECTION

Administer to the above student the following medication(s):

Medication	Dose	Route	Time	Diagnosis/Condition
_____	_____	_____	_____	
_____	_____	_____	_____	
_____	_____	_____	_____	

Possible Side effects:_____

Other medications taken (at home): _____

Medication/Emergency Plan: *If student fails to arrive at the appropriate time or refuses this medication:*
Call to Health Office ☐ Omit dose☐ Call parent ☐ Notify provider ☐ Other _____

I have instructed this student in the proper use of the above listed medication(s). In my professional opinion, _____ MAY ☐ / MAY NOT ☐ carry and use this medication him/herself, during school, if approved by the school nurse.

_____***MD/DO/DDS/CNP***_____
Printed name of provider **(Circle one)** **Telephone number**

_____
Signature of provider **Date** **Approved by school nurse** **Date**

6/12