## CONCORD PUBLIC SCHOOLS CONCORD CARLISLE REGIONAL SCHOOL DISTRICT

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

Under Massachusetts general Laws (MGL) Chapter 112, Section 80B, a licensed nurse must have a medication order from a physician, dentist, nurse practitioner, or 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 below 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	
Frequency	Time(s) during day to be given	ven
Potential side effects		
Discontinuation date		
Other Medications currently taking _		
Consent for self-administration (if th	e School Nurse determines it is	s safe and appropriate) YesNo
Physician's signature	Date	Telephone number
Parent or Guardian:		
I, the undersigned, give permission to my child.	o the School Nurse/Designee to	administer the above named medication
I give permission for my son/daughte determines it is safe and appropriate.  Yes No		medication if the School Nurse
I understand I may retrieve the medio destroyed if it is not picked up within close of school		me, however the medication will be on of the order or one week beyond the
Parent/Guardian Signature	Date	Telephone number(s)