

Old Colony

Regional Vocational Technical High School District

476 North Avenue, Rochester, Massachusetts 02770-1811

Telephone: (508) 763-8011 Fax: (508) 765-9821

Permission Form for Prescribed Medication

Date form received by the school: _____

To be completed by the parent/guardian

Student: _____ Date of birth: _____

Grade: _____ Shop Area _____

I give permission for (student) _____ to receive the medication mentioned below at school according to standard school policy.

Date: _____ Signature: _____ Relationship: _____

Physician's Name: _____

Address: _____

Phone Number: _____

To be completed by the physician or authorized prescriber

Please indicate if student needs a reminder to report to school nurse to be medicated:

No Yes How? _____

Reason for medication/Diagnosis: _____

Name of medication: _____

Route of administration: _____

Dosage: _____

Date of Order: _____ Discontinue Date: _____

Other: _____

This student is both capable and responsible for self-administering this medication:

No Yes-Supervised Yes-Unsupervised

This student may carry this medication: No Yes

Date: _____ Signature of MD: _____