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 to Dispense Prescribed Medication

Date form received by the school: _____
Student: _____ Date of birth or age: _____
Grade: _____ Teacher/Classroom_____

To be completed by the physician or authorized prescriber

Reason for medication: _____
Name of medication: _____
Form of medication/treatment:
☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other
Instructions(*Schedule and dose to be given at school):*_____
_____

START: ☐ date form recieved Other Date: _____
STOP: ☐ end of school year Other date/duration: _____
OTHER: ☐ For episodic/emergency events only

Restrictions and/or important side effects: ☐ Non anticipated ☐ Yes
Please describe: _____
Special Storage Requirements: ☐ None ☐ Refrigerate
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
Please indicate if you have provided additional information:
☐ On the backside of this form ☐ As an attachment
Date: _____ Signature: _____

Physician's Name: _____
Address: _____
Phone Number: _____

To the school: Please report concerns about medications or disease to the above physician.
To be completed by parent / guardian
Give permission for (*name of child*) _____ to receive the above medication at school according to standard school policy. *(Some schools require parent/guardians to bring the application in its original container.)*

Date: _____ Signature: _____ Relationship: _____