Old Colony

Regional Vocational Technical High School District

476 North Avenue, Rochester, Massachusetts 02770-1811

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

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: ______________________