MINUTEMAN
ASPIRE ACCELERATE ACHIEVE

Medication Permission Form

Student Name: _____ **Grade:** _____ **Date of Birth:** _____

Completion of this form by the student's medical provider and parent/guardian is required for any medication to be dispensed in school. Under Massachusetts General Laws chapter 112, 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. All prescribed medications must be delivered to the nurse's office in the original pharmacy labeled container. Any over-the-counter medications must be in their original packaging.

Parent/Guardian:

By signing below, I give permission for the school nurse to contact the provider completing this form if further information or clarification is needed regarding the care of my child. By signing below, I also give permission to the school nurse (or staff delegated by the school nurse) to administer to or to supervise my child in taking the medication. I understand that the school personnel are not responsible for any problems arising from the taking of this medication, its side effects (if any), or for the omission of medication. I understand that it is the responsibility of my child to report to the health office for scheduled medication administration.

Physician:

Physician Name: _____ Telephone: _____

Please complete and sign this form if the student must take prescribed medication during school hours and it **CANNOT** be given at home:

Diagnosis: _____ Medication: _____ Dosage: _____

Route: _____ Administration Time: _____ AM ( ) PM ( ) PRN: Yes ( ) No ( )

Allergies: _____ Special Instructions/Possible Side Effects: _____

Date medication to begin: _____ Date medication to be discontinued: _____ N/A ( )

**This form will be valid for the school year in which it is dated unless specific dates are required.*

This medication may be given up to 1 hour before or after scheduled administration time. If the student does not report to the health office on their own in this allotted time, the dose will be documented as "refused". The parent/guardian will be contacted for repeated refusal of medication doses.

Required Signatures:

Physician:_____ Date:_____

Parent/Guardian: _____ Date: _____

Student:_____ Date:_____

School Nurse:_____ Date:_____

Non-Discrimination: Minuteman Regional Vocational Technical School District does not discriminate on the basis of race, color, national origin, sex, disability, religion, sexual orientation, or gender identity in its programs or activities, including its admissions and employment practices. The School District does not tolerate harassment or discrimination. An individual has been designated to coordinate compliance under Title IX and Section 504 and may be contacted through the Superintendent's Office, 758 Marrett Road, Lexington, MA 02421, (781) 861-6500, ext.7360.