

**HUDSON PUBLIC SCHOOLS
Hudson, MA 01749**

**MEDICATION ADMINISTRATION AUTHORIZATION/AGREEMENT
For Prescription AND Over-the-Counter Medications**

Student _____ D.O.B. _____ Grade _____

----- **TO BE COMPLETED BY LICENSED MEDICAL PRESCRIBER** -----

Medication _____ Dose/Route _____ Time _____ Interval _____
 Tablet/capsule Liquid Inhaler Injection Nebulizer Other _____

Diagnosis for which medication is prescribed: _____

Start date: _____ Discontinuation date: _____

Significant side effects, precautions: None anticipated Yes – describe: _____

Other medications taken by student: _____

Medication allergies: _____

Other medical conditions: _____

At the discretion of the parent, licensed provider and the school nurse, this student may carry and self-administer emergency medication listed above, with appropriate follow-up with school nurse/personnel.
(No student may carry or self-administer any psychotropic or controlled medication.)

Under this condition: Unsupervised, with a contract Field trips only, under supervision

Printed name of Licensed Prescriber _____ Signature _____

Address _____ Phone _____ Date _____

----- **TO BE COMPLETED BY PARENT/GUARDIAN** -----

I request that the above medication be administered to my child as prescribed, by a school nurse or her/his designee. I will bring the medication in the original, properly dated and labeled container, will keep a dosage count at home, and will deliver refills as needed. I will promptly pick up any unused medication.

Permission to share this information with appropriate school staff: Yes No

Parent/Guardian Signature _____ Daytime Phone _____ Date _____

Disposition of medication: Finished Returned to parent/guardian Disposed – Witness: _____

Nurse Signature: _____ Date: _____