MONTACHUSETT REGIONAL VOCATIONAL TECHNICAL SCHOOL
MEDICATION ORDER/PERMISSION FORM

Student: _____Grade: _____

Address: _____ Birthdate: _____

To be completed by parent/guardian:

1. My child is currently receiving the following medications: *_____
2. My child has the following food and/or drug allergies: _____
3. I consent to have the School Nurse or other personnel designated by the School Nurse administer the medication prescribed by _____ to _____.
   Licensed Prescriber Student's name
4. I give permission for my child to self-administer medication, if the School Nurse determines it is safe and appropriate. ( )YES ( )NO
5. I give permission for the teacher or other school support staff to be notified of medication. ( )YES ( )NO
6. The medication should be administered on 1/2 days. ( )YES ( )NO

I give permission for my child to receive the medication as directed below.

Parent/guardian Signature: _____ Date: _____
Parent/guardian printed name: _____ Home Phone #: _____
Work Phone #: _____ Emergency Phone #: _____
Note: 1.whenever possible, medications should be administered at home.
2.medication not picked up one week after the close of school will be destroyed

To be completed by Physician/Dentist:

Name of medication	Dosage	Frequency:	Route:	Duration/DC Date:	Illness/condition:
1.					
2.					
3.					
4.					

1. Indicate any restrictions, special instructions, contraindications, side effects on any of the above medications:
_____

2. Can the medication be self-administered at the discretion of the School Nurse? YES( ) NO( )

3. Diagnosis/ Any other medical conditions: *_____
*(complete if not in violation of confidentiality)

Physician/Dentist Signature: _____Date: _____

Physician/Dentist printed name: _____Phone#: _____

revised(2/07)