

CAPE COD LIGHTHOUSE CHARTER SCHOOL MEDICATION PERMISSION FORM

This form to be completed by physician and parent for any prescription or over the counter medications to be dispensed in school, according to Massachusetts General Laws (M.G.L.) chapter 112, § 80B.

Physician/ Health Care provider:

Please complete this form if the below named student must take prescribed medication during school hours , or on a school sponsored field trip, and it cannot be given at home.

Student's Full Name _____ DOB _____ Grade _____

Diagnosis _____ Allergies _____

Other medications taken by student: _____

Medication _____ Dose _____

Route _____ Frequency/Time _____

Any Special Instructions _____

Date medication to begin and to be discontinued _____

Possible Side Effects _____

If this is an emergency medication, i.e. Inhaler, EpiPen, etc., has student been instructed to self-administer and may he/she do so? Yes _____ No _____

Physician's Name _____ Address _____

Physician's Signature _____ Telephone _____

Note: Medication orders must be renewed at the beginning of each school year.

Parent or Guardian:

I, the undersigned, give permission to the school nurse to administer to or to supervise my child in taking the above 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.

Parent/Guardian Name: _____ Signature: _____

Home Phone: _____ Cell Phone _____ Work phone _____

Emergency Contact and Phone Number: _____

For a field trip or an emergency situation may a trained designee administer this medication? Yes ____ No ____

Is this is an inhaler, epi pen, auvi q, or diabetic supplies will the student be responsible for carry and administering their own medications? Yes ____ No ____

If NO, the medication will brought to the nurses office by an adult.

If YES, student will notify nurse when they give their medication.