BLACKSTONE - MILLVILLE REGIONAL SCHOOL DISTRICT

Medical Authorization for Prescribed Medication

To be completed by the physician or authorized prescriber

Student: ___________________________ Date of Birth: ______________ Grade: _________

Reason for Medication/Diagnosis: ____

Name of Medication: ____

Dosage and Route: ____

Time to be Given at School: ____

Duration of Medication: ____

Special Instructions: ____

Possible Side Effects: ____

Student is able to self-administer Inhaler/EpiPen: Yes ______________ No ________________

Allergies: ____

Please list any additional medication taken at home:

____

Physician Signature: ________________________________ Date: ______________________

Telephone Number: ____

To be completed by Parent/Guardian

I give permission for (name of child) _________________________________ to receive the above medication at school according to standard school policy.

Please bring medication to school in its original container.

Signature: ____ Date: ___________________

Relationship to student: ________________________________

It is the policy of the Blackstone-Millville Regional School District not to discriminate on the basis of race, color, sex, religion, national origin, homelessness, sexual orientation, gender identity, age, or disability, in its educational programs, services, activities, or employment practices; as defined and required by state and federal laws.