BLACKSTONE - MILLVILLE REGIONAL SCHOOL DISTRICT

Parent Authorization for Prescribed Medication

Student: _____ Date of Birth: _____ Grade: _____

Reason for Medication/Diagnosis: _____

Name of Medication: _____

Dosage and Route: _____

Time to be Given at School: _____

Duration of Medication: _____

Possible Side Effects: _____

Allergies: _____

Please list any additional medication taken at home:

_____

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: _____