BOSTON RENAISSANCE CHARTER PUBLIC SCHOOL
PHYSICIAN ORDER AND PARENT PERMISSION FORM
MEDICATION ADMINISTRATION IN SCHOOL

Child's physician must fill out this section completely and sign for both prescription and over-the counter medications:

Student Name__________________________________Med. Allergies____________________

Physician Name_________________________________Tel. No.________________________

Date of Order_______________________________Length of Order_____________________

Name of Medication_______________________________________Dose__________________

Route__________________________Time to be given at school_________________________

Diagnosis(es)____

Side effects or contraindications____

May child self-administer if school nurse determines that it is safe and appropriate? Yes / No

Physician Signature____

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Parent/guardian must fill out this section completely and sign for any medication to be given in school:

Student Name______________________________ Date of birth ________Homeroom__________

Parent/guardian name________________________Daytime phone__________________________

Emergency contact______________________________Telephone___________________________

Name of Medication_____________________________Exact dose__________________________

Any food or drug allergies____

I give permission to the school nurse (1) or delegate to administer medication as prescribed by my child's physician (2) to share relevant information about the prescribed medication as she/he determines appropriate for my child's health and safety (3) to determine if self-administration of medication is safe and appropriate for my child's health.

Parent/guardian signature:____

PLEASE REVIEW SCHOOL MEDICATION POLICY. MEDICATION WILL NOT BE ADMINISTERED IN SCHOOL IF MEDICATION POLICIES ARE NOT OBSERVED. SECURE FAX NUMBER IS: 617-338-2580

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