Pioneer Valley Performing Arts Charter Public School
Medication Authorization Form

To be completed by a licensed prescriber

Student's Name_____ DOB_____

Diagnosis_____ Grade_____

Medication:_____

Route of Administration:_____ Dosage: _____

Frequency:_____ Time(s) of Administration_____

Date of Order_____ Discontinuation Date____

Possible side effects/adverse reactions to watch for_____

Other medications being taken by student_____

Any other medical conditions (if not in violation of confidentiality)_____

Consent for self-administration: D YES D NO

Name of Licensed Prescriber:_____ Title:_____

Business Phone Number_____ Emergency Phone Number_____

Signature of Licensed Prescriber:_____

To be completed by a parent/guardian

I authorize the School Nurse or designee to give the above named medication to my child.

Student's Name_____ Grade_____

Signature of parent/guardian_____ Date_____

EMERGENCY CONTACT_____ PHONE #_____

List of other medications_____

I give permission for my child to self-administer medication if the school nurse determines it is safe and appropriate.

D YES D NO

I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medicine administration, IE: adverse side effects, as she/he determines it necessary for my child's health and safety.

D YES D NO

Any restrictions on release?_____

I understand that I may retrieve the medicine from the school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order, or by the last day of school.

Parent/Guardian Signature_____ Date_____