

WACHUSETT REGIONAL SCHOOL DISTRICT

Physician Medication Order/Parent Consent Form

Physician Medication Order

Student Name _____ Gender _____ Date of Birth _____ Grade _____

Name of Medication _____ Dosage _____ Route _____ Frequency _____

Time of Administration at school _____ Diagnosis _____ Begin Date _____

Discontinue Date _____ Allergies _____ Contraindications _____

Common Side Effects _____

Physician Signature _____ Date _____

Physician Consent to carry and self administer medication: Yes _____ No _____

Phone _____

Parent Consent

I give permission for my child, _____, to receive the above ordered medication from the school nurse as prescribed and directed by her/his physician.

I give parental consent for my child to carry and self administer the above medication (*Provide the school nurse determines it is safe and appropriate and it is not a controlled substance*) Yes _____ No _____

Parent Signature _____ Date _____