HOLYOKE PUBLIC SCHOOLS
A PATHWAY FOR EVERY STUDENT

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Parental Consent and Medication Order

Authorization for Medication to be Administered During School Hours

Parent/Guardian to complete and sign top half of form/Bring to licensed prescriber to complete and sign bottom half of form/Return to school nurse

Student's Name: _____Date of Birth: _____ Sex: _____ Allergies: _____
School: _____ Grade: _____ Teacher: _____
Parent/Guardian: _____Relationship to Student: _____Date: _____

My son/daughter is currently taking the following medications (include all medications, even those during school hours)
1._____ 2. _____
3._____ 4. _____
Can student self-medicate, if determined to be appropriate by nurse? Yes ___ No ___
I request that my son/daughter be given the medication described below by the school nurse as authorized by myself and my provider below. (Please note: *I understand that I may retrieve the medicine from school at any time and the medicine will be destroyed if it's not picked up within one week of termination of the order or at 11 a.m. on the last day of school/summer school, if applicable*).

_____ _____ _____ _____
Signature of Parent/Guardian cell phone home phone work phone

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The following to be completed by the Physician or other Licensed Provider as authorized by Chapter 94C
ONE MEDICATION PER FORM *Whenever possible medications should be scheduled outside school hours*

Diagnosis for medication given:
_____

Name of Medication: _____ Route: _____Dose: _____ Time: _____
Can student self-medicate, if determined to be appropriate by nurse? Yes ___ No ___
Significant Side Effects:
_____

Date to Start: _____ Date to Discontinue: _____

Printed Name of Licensed Provider: _____

Signature of Licensed Prescriber: _____
Date: _____ Office Phone: _____ Other emergency phone:_____
Other Information:
_____

School Nurse's Signature: _____
Date: _____