



**EASTHAMPTON PUBLIC SCHOOLS**  
**AUTHORIZATION FOR DISPENSING MEDICATION IN SCHOOL**

TO BE COMPLETED BY PHYSICIAN: (Please Print)

It is necessary that my patient receive the following medication during school hours:

Student Name \_\_\_\_\_ DOB \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Name of Medication \_\_\_\_\_ Dosage: \_\_\_\_\_

Time(s) to be Given \_\_\_\_\_ Route: \_\_\_\_\_

Duration of treatment \_\_\_\_\_

Possible Side effects/adverse reactions \_\_\_\_\_

Other recommendations: \_\_\_\_\_

Consent for self-administration: YES \_\_\_\_\_ NO \_\_\_\_\_

Please print physician name and address: \_\_\_\_\_

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Date

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**TO BE COMPLETED BY PARENT:**

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

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

\_\_\_\_\_  
Signature of parent or legal Guardian

\_\_\_\_\_  
Date

EMERGENCY CONTACT \_\_\_\_\_ Number \_\_\_\_\_

List of other medications \_\_\_\_\_

I give permission for the school nurse to share the above information with appropriate school personnel, when necessary for the child's health and safety. Yes \_\_\_\_\_ NO \_\_\_\_\_

**Note:** *the parent or guardian in an appropriate container with a pharmacy label must furnish all medication.*