

CANTON PUBLIC SCHOOLS *HEALTH SERVICES*

Medical Provider Permission to Administer Medications in School

Name of Student: _____ Date of Birth: _____

Street Address: _____ Grade: _____

City/Town: _____

Name of Licensed Prescriber: _____ Title: _____

Business Telephone Number: _____

Emergency Telephone Number: _____

Medication: _____

Route of Administration: _____ Dosage: _____

Frequency: _____ Time(s) of Administration _____

Please note: Whenever possible, medication should be scheduled at times other than school hours.

Specific directions or information for administration: _____

Date of Order: _____ Discontinuation Date: _____

*Diagnosis: _____

*Any other medical condition(s): _____

*Other medications being taken by the student: _____

*If not in violation of confidentiality.

Specific side effects, contraindications, or possible adverse reactions to be observed:

Date of the next scheduled visit or when advised to return to prescriber: _____

Consent for the self-administration. (Provided the school nurse determines it is safe and appropriate). Yes _____ No _____

Signature of Licensed Prescriber

Date