

For School Year
2009 - 2010

SOUTH KINGSTOWN SCHOOL DEPARTMENT
Authorization for Prescription Medications to be Taken During School Hours
(PHARMACY-LABELED CONTAINERS ONLY)

School _____ Grade/Teacher _____

CHILD'S NAME _____ Sex _____ Date of Birth _____

Physician's Name/Address _____
Physician's Telephone _____

The following section is to be completed by the PARENT:

*I request that my child be assisted in taking the medicine(s) described below at school by the school nurse-teacher or permitted to medicate himself/herself as also authorized by me and my physician - see below.**

Additionally, in the event of an off site school-sponsored activity, my child may self-administer this medication which shall be provided from home. Only one school day's supply should be provided and it will be transported in its original pharmacy-labeled container. This medication will be sent in on the day of the field trip. (If this procedure is not followed, the student will not be allowed to self-medicate on the off-site school sponsored activity.)

YES NO

I have read and understand the medication policy on the back of this page YES NO

Parent/Guardian Signature _____

Date _____

Home Phone _____

Emergency Phone _____

The following section is to be completed by the PHYSICIAN:

Diagnosis for which medication is prescribed: _____

Name of Medicine _____

Dose/Time _____

Directions for Administration _____

List significant side effects _____

Length of time this treatment is recommended _____

**Is child authorized to medicate himself/herself?* YES NO

(Self medication applies only to inhalers, Epi-Pens and prescribed self injected medication.)

**Is child authorized to self medicate during an off site school-sponsored activity?* YES NO

Physician's Signature _____

Date _____