

Permission Form for Prescribed Medication

School: Douglas Primary School
17 Gleason Court
Douglas, MA 01516

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Date form received by the school: _____

Student: _____ Date of birth, or age: _____

Grade: _____ Teacher/Classroom: _____

To be completed by the physician or authorized prescriber

Reason for medication: _____

Name of medication: _____

Form of medication/treatment:

☐ Tablet/capsule ☐ Liquid ☐ Inhaler ☐ Injection ☐ Nebulizer ☐ Other

Instructions (schedule and dosage to be given at school): _____

Start: ☐ date form received other date: _____

Stop: ☐ end of school year other date/duration: _____

☐ For episodic/emergency event only

Restrictions and important side effects: ☐ None anticipated

☐ Yes. Please describe: _____

Special storage requirements: ☐ None ☐ Refrigerate ☐ Other

This student is both capable and responsible for self-administering this medication:

☐ Yes ☐ No ☐ N/A

Please indicate if you have provided additional information:

☐ On the back side of this form ☐ As an attachment

Date: _____ Signature: _____

Physician's Name:
Address:
Phone Number:

To the school: Please report concerns about medications or condition to the above physician.

To be completed by parent/guardian

I have read and understand the Douglas Public Schools' medication policy. I give
permission for (name of child) _____

to receive the above medication at school according to school policy.

Date: _____ Signature: _____ Relationship: _____