# Boston Public Schools - Parent/Guardian Authorization for Medication Administration

Date ___/___/___

Dear Parent or Guardian,

I would like to inform you of the policies that have been put in place to ensure the health and safety of children needing medication and other health-related accommodations during the school day.

The school district and/or state regulations requires that the following forms must be on file in your child's health record before we begin to give any medication or make any accommodation at school.

1. ***Signed consent by a parent/guardian to give medication*** - Please complete the consent form included with this letter and give it to the school nurse. There may be several forms. Please call the school nurse if you have any questions.
2. ***Signed medication order*** - The written medication order form should be taken to your child's primary care provider (your child's physician, nurse practitioner, etc.)for completion and returned to the school nurse. This order must be renewed as needed and at the beginning of each school year.
3. ***Individual Collaborative Health Plan*** - This form provides the necessary information to maintain a safe environment that meets your child's individual health needs and is a prerequisite if your child will require any additional accommodations beyond medication. If your child does not have any significant health problems, you do not need to complete this form. (Children with asthma should ask their primary care provider or the school nurse about an *Asthma Action Plan*).

Medications should be delivered to the school in a pharmacy or manufacturer-labeled container by you (parent/guardian) or a responsible adult whom you designate. Please ask your pharmacy to provide separate bottles for school and home. No more than a (30) thirty-day supply of the medication should be delivered to the school.

When your child needs a medication to be given during the school day, please act quickly to follow these policies so we may begin to give the medication as soon as possible.

I understand I may retrieve the medication from the school at any time; *however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.*

Thank you for you assistance and cooperation with this matter.

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School Nurse:_____ RN School Phone:_____

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**PARENT or GUARDIAN:**

I request that my child _____ receive medication as prescribed in the form below.

By: _____ _____

*Name of Primary Care Provider* *Signature of Parent or Guardian*

Telephone Number: _____ Date: _____

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***Signed medication order*** - The written medication order form should be taken to your child's primary care provider (your child's physician, nurse practitioner, etc.) for completion and returned to the school nurse. This order must be renewed as needed and at the beginning of each school year.

**PHYSICIAN - I request that my patient receive the following medication:**

Name of Student: _____

Diagnosis: _____

Names of Medication: _____

Prescribed Dosage: _____

Time to be taken during school hours: _____

Expected duration of treatment: _____

Possible side effects and adverse reactions: _____

_____

Other Recommendations: _____

Print Name: _____ Clinic: _____

Signature: _____ Date: _____

Telephone #: _____ Fax #: _____

E-mail: _____