Boston Public Schools - Parent/Guardian Authorization for Medication Administration

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: _____

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: Life Threatening Allergy

Names of Medication: Epinephrine Auto Injector

Prescribed Dosage: 0.3 mg IM

Time to be taken during school hours: ***Signs/Symptoms of a life threatening allergy***

then call 911

Expected duration of treatment: School Year

Possible side effects and adverse reactions: **tachycardia or anaphylaxis if no response to medication**

Other Recommendations: _____

Print Name of Medical Provider:: _____

Signature of Medical Provider: _____

Date: _____ E-mail: _____

Telephone #: _____ Fax #: _____