

Boston Public Schools – Self Medication Administration Form

Parent/Guardian Authorization for Prescription Self Medication Administration

Student: _____ DOB: _____ Grade: _____

Diagnosis: _____

Medication/Dosage: _____

Frequency: _____

Time or circumstances when medication is given: _____

Side Effects: _____

Parent/Guardian: Name(printed): _____

Telephone Numbers:

Home: _____ Cell: _____

Work: _____ Alt: _____

Emergency: _____

Other person(s) to be notified in case of medication emergency:

Name: _____

Home: _____ Cell: _____

Work: _____ Alt: _____

Parent Agreement: I agree with the plan to allow my child to self-medicate as outlined above.

_____ Date: ____/____/____

Parent Signature

- () Teacher Training Completed
- () Student Demonstrates Understanding
- () Storage Area Secure
- () Standard Medication Protocol in Place

School Nurse: _____ Date: ____/____/____