St. John the Evangelist School

696 Washington Street
Canton, MA 02021
(781) 821-1353/ fax (781) 828-7563

Medical Provider Permission to Administer Medications in School

Name of Student: _____ **Date of Birth:** _____

Street Address: _____ **Grade:** _____

City/Town: _____

Name of Licensed Prescriber: _____**Title:** _____

Business Telephone Number: _____

Emergency Telephone Number: _____

Medication: _____

Route of Administration: _____ **Dosage**: _____

Frequency: _____ **Time(s) of Administration** _____
Please note: Whenever possible, medication should be scheduled at times other than school hours.

Specific directions or information for administration: _____

Date of Order: _____ **Discontinuation Date:** _____

Diagnosis: _____

Any other medical condition(s) *If not in violation of confidentiality: _____

_____

Other medications being taken by the student:_____

_____

Specific side effects, contraindications, or possible adverse reactions to be observed:

_____

Date of the next scheduled visit or when advised to return to prescriber: _____

Consent for the self-administration: (Provided the school nurse determines it is safe and appropriate)
Yes_____ No_____

_____

Signature of Licensed Prescriber **Date**