Shawsheen Valley Technical High School

Nurses' Office
Parent/Guardian Authorization for Medication Administration

This written Parent/Guardian Authorization for Medication Administration form should be filled out by a parent or guardian and returned to the school nurse. This form must be renewed as needed and at the beginning of each academic year. Any prescription medication to be administered during school must have an accompanying Medication Order form completed and submitted to the school nurse.

Student Information

Student's Name: ______________________ Address: ______________________

Date of Birth: ______________________ ______________________

Grade: ______________________ Shop: ______________________

Medication to be taken in school: ______________________

Diagnosis: ______________________

Allergies: ______________________

Other Pertinent Information: ______________________

Parent/Guardian Information

Name: ______________________ Phone: ______________________

Name: ______________________ Phone: ______________________

I authorize the school nurse or school personnel designated by the school nurse to administer the medication listed above. Yes ☐ No ☐

I authorize my student to self-administer the medication listed above. *(appropriateness may be evaluated by school nurse)* Yes ☐ No ☐

I authorize the school nurse to share information about this medication to appropriate staff as determined necessary for my student's health and safety. Yes ☐ No ☐

Signature of Parent/Guardian: ______________________ Date: ____________

Shawsheen Valley Technical High School

Nurses' Office
Medication Order Form

This written medication order form should be taken to your child's licensed prescriber (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 academic year.

Student Information

Student's Name:	______________	Address:	______________
Date of Birth:	______________		______________
Grade:	______________	Shop:	______________

Provider Information

Provider's Name:	______________	Phone:	______________
Provider's Office:	______________	Fax:	______________

Medication Information

Medication:	______________	Diagnosis:	______________
Dose:	______________	Side Effects:	______________
Route:	______________	Contraindications:	______________
Frequency:	______________	Date of Order:	______________
Time of administration:	______________	Date of Discontinuation:	______________

Consent for self-administration *(appropriateness may be evaluated by school nurse.)* Yes ☐ No ☐

Signature of Licensed Prescriber: ______________________ Date: ____________