BOSTON COLLEGIATE
CHARTER SCHOOL

AUTHORIZATION FOR DISPENSING
PRESCRIPTION MEDICATIONS IN SCHOOL
For the 2019-2020 School Year

Please have your child's doctor fill out the following information for any prescription medication to be given out during school.
Your child CANNOT receive prescription medication in school without both doctor and parent consent.

I request that the student below receive the following medication during school hours:

Student Name: _____

Student Grade: _____

Student Date of Birth: _____

Name of Medication: _____

Prescribed dosage: _____

Time to be taken during school hours: _____

Expected duration of treatment: _____

Possible side effects and/or adverse reactions: _____

_____

Other recommendations: _____

_____

This order is for the 2019-2020 school year. I understand that the school nurse will require a new medication order every school year that the student above will need to take this medication during school hours.

Physician or NP Name (please print): _____

Physician or NP Signature: _____

Physician or NP Telephone number: _____

Date: _____

Parent/Guardian Name (please print): _____

Parent/Guardian signature: _____

Parent/Guardian Telephone number (that can reached during school hours): _____

Date: _____