Spencer East Brookfield Regional School District
Student Services Department
302 Main Street, Spencer, Massachusetts 01562
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Director of Student Services Department: David Gates

Physician Medication Authorization Form

Name of Student _____

Date of Birth _____

Address_____ Grade _____

Medication_____

Route of administration_____ Dosage_____

Frequency_____ Time(s) of Administration_____

Specific directions or information for administration:
_____

Date of Order_____ Discontinuation Date_____

Diagnosis*_____

1. Special side effects, contraindications, or possible adverse reactions to be observed:
_____
2. Other medication being taken by the student:
_____

3. Consent for self-administration (provided the school nurse determines it is safe and appropriate).
Yes_____ No_____
* If not in violation of confidentiality.

*Medical Provider Signature_____Date_____

*Medical Provider Phone number: _____

Parent/Legal Guardian Name _____I, the undersigned, give permission to the school personnel to administer to my child, the above-medication. This information may be released to pertinent school staff, as is deemed necessary by nursing staff.

Signature Parent/Legal Guardian_____
