



Spencer East Brookfield Regional School District

Student Services Department

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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 _____

The Spencer-East Brookfield Regional School District's Policy of non-discrimination will extend to students, staff, the general public and individuals with whom it does business; and will apply to race, color, national background, religion, sex, disability, economic status, political party, age, handicap, sexual orientation, gender identity, homelessness and other human differences.