SOMERSET PUBLIC SCHOOLS SOMERSET BERKLEY REGIONAL HIGH SCHOOL School Health Services

Medication Order/Parental Consent for Administration of Medication at School (Based on 105 CMR 210.000)

1. PARENT/GUARDIAN SECTION: (to be filled out completely and signed)

DATE:	SCHOOL:		GRADE:
I hereby request the Schoo	Nurse see that my child:		receives the medication
prescribed by:	f	or the period from:	to
with the child's name, name		and time that the medic	y or manufacturer labeled container cation is to be given. The medication
For Elementary students trips ONLY, if the School Nurse	s only: I give permission for my chi e determines it is safe and appropria	ild to self-carry/self-admir te: (circle one): <u>Y</u>	nister INHALER or EPI-PEN during field <u>(ES NO</u>
For Middle and High School School Nurse determines it is s	I students: I give permission for mage and appropriate: (circle one):	y child to self-carry/self-a <u>YES</u> <u>NO</u> <u>I</u>	dminister INHALER or EPI-PEN, if the FIELD TRIPS ONLY
PARENT/GUARDIAN'S NAME (PLEASE P	//	PARENT/GUARDIAN'S SIGNATU	RE
Home:	Work:	Cel	:
	t/guardian unavailable:		
2- PHYSICIAN/ LOENSE	DERESERUBERESECTION (` '	•
	nder my care. Please administer		
NAME OF MEDICATION:			
DOSAGE:	ROUTE:		
FREQUENCY/TIME(S) TO	BE GIVEN AT SCHOOL		
	NT:/_		
	(START DATE)	(END DATE)	_
DIAGNOSIS:			_
	e for the above mentioned st urse determines it's safe and		self-administer INHALER or ES <u>NO</u>
PHYSICIAN'S NAME:	(PLEASE PRINT)		DATE:
PHYSICIAN'S SIGNATURE: _			_
ADDRESS:			
(CITY)	(STATE) (ZIP)	(TELEDIANE)	