

**THE HARVARD PUBLIC SCHOOLS  
NURSING DEPARTMENT  
AUTHORIZATION TO ADMINISTER MEDICATION**

Bromfield (978) 456-4123 ~ Harvard Elementary (978) 456-1247

(to be completed by Licensed Prescriber and Parent)

Name of Student: \_\_\_\_\_ Grade: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Physician Name & Phone: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_  
Time given (at school): \_\_\_\_\_ Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_  
Time given (at school): \_\_\_\_\_ Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

Diagnosis For Medication(s): \_\_\_\_\_

Allergies: \_\_\_\_\_

Other Pertinent Medical Information: \_\_\_\_\_

I give permission for this student: - To carry an Epi-pen: Yes / No  
(PHYSICIAN TO COMPLETE) - To self-administer an Epi-pen: Yes / No  
- To carry and self administer an inhaler: Yes / No

Signature of Prescribing MD: \_\_\_\_\_ Date: \_\_\_\_\_

**PARENT please complete the following -**

I would like my child to receive his/her medication on early release days. Yes \_\_\_ No \_\_\_

I would like my child to receive his/her medication on field trip days. Yes \_\_\_ No \_\_\_

I hereby authorize the school nurse to administer the above medication to my child in accordance with the approved school policy for administration during the school day. I give my permission to the school nurse to share information relevant to my child's health condition with appropriate school personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis, and treatment. I give permission for a teacher, as directed by the school nurse, to administer my child's daily medication while attending a field trip.

Signature of parent/guardian: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Emergency phone: \_\_\_\_\_

This form will be filed in the student health record after the course of medication has been completed. The school nurse reserves the right to withhold administration of any non-prescription drugs that she/he questions pending approval by the students' physician.

**THIS PERMISSION FORM MUST BE COMPLETED AND RETURNED TO THE SCHOOL NURSE WITHIN 24 HOURS OF THE FIRST ADMINISTRATION OF MEDICATION.**

