CRANSTON PUBLIC SCHOOLS

845 Park Avenue
Cranston, Rhode Island 02910-2790

MEDICATION AUTHORIZATION

School____Grade__________Room__________

Student Name____
(Last) (First) (Date of Birth)

Address____Home Phone_______________

I understand that special permission is required for the use of medication by students during school hours and that the School Nurse is authorized to consult with the prescribing physician on matters relating to this order. I request that my child be given the medication described below or be permitted to self-carry/self-medicate as authorized by me and my physician.

____
(Parent/Guardian Signature) (Date)

____

This Section To Be Completed by Physician

Medication____________________________________Daily______________PRN________

Dose__________________Route___________Time_______________Frequency____________

Describe Indications____

Side Effects____

Related Diagnosis_________________________________Allergies______________________

Other Information____

____

____

This child is authorized to self-carry and/or self-medicate in school, on a field trip, or activity away from school (excludes controlled substances). Yes______No______

____
(Physician Signature) (Date)

H-10b
10/08