

Stoughton Public Schools
Stoughton, MA

Parent/Guardian Medication Administration Form

Name of Student: _____ Date of birth _____

School: _____

Grade: _____ Room: _____

Name of Licensed Prescriber: _____

Food/Drug Allergies: _____ Diagnosis: _____

_____ to be given at _____

Name of medication & Dosage _____ Time _____

For a period from _____ to _____

I give permission for teacher/chaperone to administer medication for field trips and other short-term school events. Yes ___ No ___

I give permission for my son/daughter to self-administer medication if the School Nurse determines it is safe and appropriate. Yes ___ No ___

This medication is to be supplied in a properly labeled container from the pharmacy or physician.

Parent /Guardian Signature: _____

Date: _____