TAUNTON PUBLIC SCHOOLS
NURSING DEPARTMENT
Medication Authorization (Physician)

School: ____________________
School Year: ________________
Student Name: ______________________________ DOB: __________   GRADE: _______

Allergies_______________________________________________________________________________

All medications below are authorized for the current school year including any Summer School Programs.

Date of Order______________________                      Discontinuance Date__________________________

Medication_____________________________________________________________
Route of Administration_____________________ Dosage_____________________

Time(s) of Administration______________________ Frequency___________________

Diagnosis*______________________________________________________________

Specific Instructions for Administration________________________________________________________

Possible Side Effects, Contraindications, Adverse Reactions:
_______________________________________________________________________________________

Other medications being taken by student_____________________________________________________

Student May Self Administer Medication:
For Field Trips:             YES_____   NO_____
During School Hours:  YES_____   NO_____

Please note, whenever possible, medication should be scheduled at times other than school hours.

________________________________________
Name of Licensed Prescriber (Please print)

________________________________________
Signature of Licensed Prescriber

Business Phone / Emergency Phone___________________________

*If not in violation of confidentiality

3/12/18