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