# Littleton Public Schools

Date form completed: _____

## MEDICATION PERMISSION FORM

***Please complete this form for any medications to be dispensed in school.***

***Additionally, Physician's orders must accompany this form for each medication.***

**Note**: Medications should be delivered to the school in a pharmacy or manufacturer-labeled container by you or a responsible adult whom you designate. Please ask your pharmacy to provide separate bottles for school and home. No more than a thirty-day supply of the medicine should be delivered to the school. This Medication Permission Form must be renewed at the beginning of each school year.

**Under Massachusetts General Laws (M.G.L.) chapter 112, § 80B, a licensed nurse must have a medication order from a physician, dentist, nurse practitioner, or physician's assistant in order to administer any medication, whether it is a prescription drug or over-the-counter medication.**

Student's Name: _____ DOB: _____ Grade: _____

Diagnosis: _____ Allergies: _____

Medications Taken at Home: _____

Medication to be dispensed at school (#1): _____

Dosage Prescribed: _____ Route: _____ Time to be administered: _____

Date medication to begin and to end: _____ Is medication to be given on field trips? ▢ Yes ▢ No

Special Instructions: _____

Possible Side Effects: _____

If this is an emergency medication (i.e. inhaler, EpiPen, etc.), has the student been instructed to self-administer and may they do so if the school nurse deems self-administration safe and appropriate? ▢ Yes ▢ No

Medication to be dispensed at school (#2) _____

Dosage Prescribed: _____ Route: _____ Time to be administered: _____

Date medication to begin and to end: _____ Is medication to be given on field trips? ▢ Yes ▢ No

Special Instructions: _____

Possible Side Effects: _____

If this is an emergency medication (i.e. inhaler, EpiPen, etc.), has the student been instructed to self-administer and may they do so if the school nurse deems self-administration safe and appropriate? ▢ Yes ▢ No

I, the undersigned, give permission to the school nurse (or school personnel designated by the school nurse) to administer to or to supervise my child in taking the above medication if approved to do so by the school nurse. I agree to indemnify and hold harmless the town of Littleton, the Littleton School Committee and their employees and agents from and against any claim either I or my child may have as a result of any act or omission which may arise out of this authorization. I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Parent/Guardian Name | Parent/Guardian Signature | Date | Telephone |