# BLUE HILLS REGIONAL TECHNICAL HIGH SHOOL
# MEDICATION ORDER FOR PHYSICAN AND PARENT

**To be completed by Physician:**

Is it necessary that the following medication be given during school hours? Yes____ No____

Name of student:_____ DOB:_____

Medication:_____ Dosage:_____

Start Date:_____ Stop Date:_____

Special instruction/possible side effect/known allergies_____

_____

*Diagnosis (if not confidential)_____

_____ _____
Physician's Signature Date

_____ _____
Address Telephone

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**To be completed by parent or guardian:**

Student's Name: (print)_____DOB:_____Grade_____

Your telephone number: (home)_____Cell/work_____

1. I give permission for the school nurse or designee to administer the above named Medication as prescribed

2. This medication is being taken for:_____

3. List any other medications your child takes:_____

4. Physician's Name: (please print)_____

5. I give permission to the school nurse to inform appropriate school personnel relative to the prescribed medicine administered to my child.

Yes_____ No_____

Please Note: I understand that I may retrieve the medication from the school nurse at any time and that the medication will be destroyed if it is not picked up within one week following the termination of the order.

Signature of Parent/Guardian:_____Date:_____

***Please refer to the reverse side for parental consent for Tylenol or Advil****

## Parent Consent for Tylenol and Advil:

**I give permission for the school nurse or designee to administer Tylenol 650 mg or Advil 400 mg by mouth for complaints (headache, menstrual cramps)**

**The student will only be allowed to take such medication once during the school day and at the discretion of the nurse or designee.**

**Students must bring their own medications. They must be in the original container and will be available for the designated student only.**

**Student Name:**_____**Grade**_____

**Phone:(home)**_____**DOB**_____

**Parent Signature:**_____

**Parent Name: (print)**_____

**Parent cell:**_____

**Parent work:**_____