

City of Newton



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Mayor

HEALTH AND HUMAN SERVICES DEPARTMENT

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Public Health  
Prevent. Promote. Protect.

**MEDICATION PERMISSION FORM & POLICY**

This form must be completed by a **health care provider** and **parent** before any medication (over-the-counter or prescription) can be administered at school. (M.G.L. Chapter 112 § 80)

Student name \_\_\_\_\_ School \_\_\_\_\_ Grade: \_\_\_\_ D.O.B.: \_\_\_\_\_ M/F

**HEALTH CARE PROVIDER:** Please complete a separate form for each medication to be administered at school.

**Medication** \_\_\_\_\_ **Dosage** \_\_\_\_\_ **Route** \_\_\_\_\_

**Frequency** \_\_\_\_\_ **Time(s) to be given at school** \_\_\_\_\_

Possible side effects: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Date of order: \_\_\_\_\_ Discontinuation date: \_\_\_\_\_

Diagnosis \_\_\_\_\_ Drug/Food Allergies: \_\_\_\_\_

Name of licensed prescriber: \_\_\_\_\_ Title \_\_\_\_\_

Signature of licensed prescriber: \_\_\_\_\_ print \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Consent for self administration:** The student has been instructed to self administer medication and may do so at school. Yes \_\_\_\_ No \_\_\_\_ (The school nurse must determine it to be safe and appropriate.)

**PARENT/GUARDIAN:**

Print Name: \_\_\_\_\_ Relationship to student \_\_\_\_\_

Please list all other medications. \_\_\_\_\_

I, the undersigned parent or guardian, give permission to the school nurse (or school personnel designated by the school nurse) to administer the above medication to my child or to supervise my child in taking the above medication if approved to do so by the school nurse. I authorize the school nurse to share information about such medication administration as the school nurse deems necessary for the health and safety of my child. I agree to release, indemnify and hold harmless the City of Newton, the Newton 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.

Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_

Phone numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Field Trip Plan: \_\_\_\_\_

Signature of School Nurse: \_\_\_\_\_

**School Medication Administration Policy: see next page**

## SCHOOL MEDICATION ADMINISTRATION POLICY

The school nurse is responsible for the administration of all medication. She may delegate this task to other trained personnel who may administer the medication under the supervision of the nurse.

**The medication permission form (see other side) must be completed in ink and be on file in the Health Office before any medication is administered.**

The following statements highlight the main points of the policy. The entire policy is available in each health room, at the Health and Human Services Department and on the web site [www.newtonma.gov](http://www.newtonma.gov)

- Medication administration should be scheduled at times other than during school hours, whenever possible.
- All medication must be delivered by the parent/guardian or designated adult.
- Only a 30-day supply of medication will be accepted at any time.
- All medication must be delivered in a pharmacy or manufacturer labeled container.
- The pharmacy-labeled container can be used in lieu of a health care provider's order only for short-term medications, i.e. those medications to be given for 10 school days or less.
- Self medication can be allowed under certain circumstances after consultation with the school nurse.
- The school nurse must be notified **in advance** if medication is scheduled to be administered during a field trip.
- **This Medication Permission Form must be renewed at the beginning of each school year.**

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### Over-the-counter medication will be treated the same as prescription medication.

This means that medications such as Tylenol, Benadryl, Advil, etc., require a written order from a health care provider and a supply of the medication provided by the parent.

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For office use only

#### Medication Quantity Received by School:

Amnt: _____ Date: _____ Exp. Date: _____		Amnt: _____ Date: _____ Exp. Date: _____
Amnt: _____ Date: _____ Exp. Date: _____		Amnt: _____ Date: _____ Exp. Date: _____
Amnt: _____ Date: _____ Exp. Date: _____		Amnt: _____ Date: _____ Exp. Date: _____
Amnt: _____ Date: _____ Exp. Date: _____		Amnt: _____ Date: _____ Exp. Date: _____
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