Ponaganset High School
Medication Authorization Form
School Year 2021 - 2022

Student Name: _____ D.O.B _____ Grade: _____

Address: _____ 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 / licensed practitioner on matters relating to this order. I request that my child be given the medications described below or be permitted to self-carry/self-medicate as authorized by me and my physician / licensed practitioner. I understand that the school nurse is not present on field trips and that I must execute a form regarding administering medication of field trips. My signature indicates my understanding of these facts, district policy, my responsibility to ensure my child receives any necessary medication, and authorization to administer medications to my child as described below and in emergency situations.

_____ _____

Parent/Guardian Signature **Date**

This section to be completed by Physician / Licensed Practitioner

Diagnosis: _____

Medication(s): _____ Daily: _____ PRN:_____

Dose:_____ Route: _____ Time: _____ Frequency: _____

May it be repeated: _____ Start Date:_____ End Date:_____

Describe indications: _____

Side Effects: _____

Allergies: _____ Special Instructions _____

If Epi-pen or inhaler student may self-administer	Yes ☐	No ☐
If Epi-pen or inhaler student may self-carry	Yes ☐	No ☐
If on a field trip medication may be self-administered	Yes ☐	No ☐
If on a field trip medication may be delayed until child returns home	Yes ☐	No ☐
Student must self-carry / self-administer the medication	Yes ☐	No ☐

Physician Signature **Date**

Please FAX this form back to the attention of Mr. Christopher Shippee at 401-764-5813
Or email form to cshippee@fgschools.com