NORWELL STUDENT SERVICES
NORWELL PUBLIC SCHOOLS
AUTHORIZATION FOR THE ADMINISTRATION OF MEDICATIONS

The Norwell School Department requires a physician's written order and parent/guardian authorization for a nurse to administer medication to a student.

PHYSICIAN ORDER

Name of child _____

Address _____

Date of Birth _____

Allergies _____

Diagnosis _____

Name of Drug _____

Dosage _____

Time _____

Side Effects _____

Consent for self administration (provided the school nurse determines it is safe and appropriate.)

Yes _____ No _____

Physician Signature _____Date _____

Address _____Telephone # _____

AUTHORIZATION OF PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE ORDERED MEDICATION

I authorize the School Nurse to administer the above ordered medication to my child as written by his/her physician.

I give permission to the school nurse to share this information with appropriate school staff.

During school field trips only, I give permission for the school nurse to delegate medication administration to my child's teacher.

Parent/Guardian signature _____Date _____