MARTHA'S VINEYARD REGIONAL HIGH SCHOOL
HEALTH DEPARTMENT

PLAN FOR UNLICENSED SCHOOL PERSONNEL TO ADMINISTER PRESCRIPTION MEDICATION DURING FIELD TRIPS AND SHORT-TERM SPECIAL SCHOOL EVENTS

Student's Name:_____ Grade:_____

I give permission for (name of teacher):_____

to give the following medication to my child:

Name of Medication:_____

Dosage:_____ Time(s) to be given: _____

Prescribed by:_____

Name of School Event:_____ Date:_____

I give permission to the school nurse to share with the above named teacher information relative to the prescribed medication administration, e.g., adverse side effects, as she determines necessary for my child's health and safety.

Parent/Guardian Signature:_____

Date: _____

Telephone Numbers: Home: _____ Work:_____

Cell:_____