Narragansett High School
245 South Pier Road
Narragansett, RI 02882
Telephone: (401) 792-9400
FAX: (401) 792-9410

DANIEL F. WARNER, *Principal*
TOBY W. GIBBONS, *Assistant Principal*
MATTHEW MAHAR, *Athletic Director*

PHYSICIAN AUTHORIZATION FOR MEDICATION ADMINISTRATION AT SCHOOL

Student Name: _____ DOB: _____ Grade: _____

Address: _____ Primary Phone #: _____

Health Care Provider's Name: _____ Phone # _____

This Section to Be Completed By Health Care Provider

Medication & Strength	Dose	Route	Time to Administer
_____	_____	_____	_____

Reason for Medication: _____

If PRN, describe indications: _____

Significant side effects: _____

Additional information/Special instructions _____

For Non-Controlled Substances Only:

Is student allowed to self-carry medication? ____ Yes ____ No
Is student allowed to self-administer medication? ____ Yes ____ No

Field Trips / Away from School Activities Only:

Can medication be omitted for field trips/away from school activities? ____ Yes ____ No
Is student allowed to self-carry and self-administer medication? ____ Yes ____ No

_____ _____
Health Care Provider's Signature **Date**

……

This Section To Be Completed By Parent/Guardian

I understand that special permission is required for the use of medication by students during school hours.
I give permission for my child to receive the medication as authorized above by my child's healthcare provider.
I understand the school nurse teacher may contact the prescriber if needed for questions related to this medication: ____Yes ____No

_____ _____
Parent/Guardian Signature **Date**