

ADMINISTRATION of necessary PRESCRIPTION MEDICATION during the school day

*Doctor may use their own form

COTTING SCHOOL

453 Concord Avenue, Lexington, MA 02421

Name: _____ **DOB:** _____ **Allergies:** _____

In order to assure that our students receive only medications that are safe and appropriate for them, please complete, sign and have your licensed prescriber sign the following for each medication, which the student would need to have administered at school. Medication must be in the original container with the prescription label attached.

Please note: Whenever possible, medication should be scheduled at times other than school hours.

Medication Name and Strength: _____

Route of Administration: _____ Dosage: _____

Frequency: _____ Time(s) of Administration: _____

Indication: _____

Side effects, contraindications or possible adverse reactions to be observed: _____

Medication Name and Strength: _____

Route of Administration: _____ Dosage: _____

Frequency: _____ Time(s) of Administration: _____

Indication: _____

Side effects, contraindications or possible adverse reactions to be observed: _____

Medication Name and Strength: _____

Route of Administration: _____ Dosage: _____

Frequency: _____ Time(s) of Administration: _____

Indication: _____

Side effects, contraindications or possible adverse reactions to be observed: _____

Date: _____ **Parent's Signature:** _____

Date: _____ **Prescriber's Signature:** _____

Name of Licensed Prescriber: _____ Title: _____

Address: _____ (Please print) Business Phone: _____

City/Town: _____
(Zip Code)