PORTSMOUTH SCHOOL DEPARTMENT
Portsmouth, Rhode Island

MEDICATION POLICY – LONG TERM

In order for medication to be given to children in school on a long-term basis (more than 2 weeks), the following form must be signed by the parent/guardian and completed by the physician.

I authorize the school to give the following medication under my physician's directions.

____
School

____
Signature of Parent/Guardian

____
Grade and Teacher

____
Date

____
Telephone Number

DOCTOR'S ORDERS

I request that the following medication be administered to my patient as directed

Name of patient: ______________________________________
Name of medication: ___________________________________
Amount of medication: _________________________________
Time of medication: ___________________________________
Possible side effects of medication: _______________________
Reason for medication: __________________________________
Duration of medication: _________________________________

The original prescription bottle must accompany medication and medication from is to be renewed annually.

I, as physician of __________________________________,assume responsibility for medication given and do so direct it to be given.

_____ May self carry and self administer metered dose inhaler.

_____ May self-administer medication on school sponsored field trips.

_____ May omit medication on school sponsored field trips.

____
Date

____
Signature of Physician