The MacDuffie School

PRESCRIBED MEDICATION AUTHORIZATION FORM

Student Name: _____ **Date of Birth:**_____
(LAST) **(FIRST)** **(M/D/YY)**

Under Massachusetts General Law (M.G.L.) chapter 112,§ 80B, a licensed nurse must have a **United States** based medication order from a physician, dentist, nurse practitioner, or physician's assistant in order to administer any medication. All controlled substance medication orders must be from a **Massachusetts** physician. Students requiring prescribed medication while at school must have a current (within 1 year) Medication Authorization Form on file and must include both the physician and parent/guardian signatures.

****Boarding students outside of the United States will be sent to the MacDuffie School affiliated physician to obtain United States based medication order(s). This form can be used as a suggestion for the physician to view. The physician has the right to refuse to prescribe any suggested medications if deemed the medication regimen is unsafe or not appropriate for the student.** ***The family will be required to pay for any billing not covered by the student health insurance.*****

The parental signature below gives MacDuffie School permission to access all pertinent information, from your child's physician, regarding the dispensing of the medication listed below, and permits authorized MacDuffie School persons to administer or assist the student in taking the medication listed below. Medications are to be kept in the nurse's office, and must be brought to the nurse's office by the legal guardian of the student. Students may self medicate when authorized by the physician, parent, AND school nurse.

_____ _____
(SIGNATURE OF PARENT/GUARDIAN or STUDENT AGE 18+) (DATE)

***Please note: This form is not required for occasional use of over-the-counter (OTC) medications (e.g. Tylenol, Ibuprofen, Motrin, Benadryl, etc.) that are listed on the OTC medication authorization form.**

THE FOLLOWING IS TO BE COMPLETED BY A PHYSICIAN. *All fields required*

Name of Medication: _____

Dose: _____ Time of Administration: _____Route:_____

Diagnosis/Indications for which the medication is given: _____

Start date: _____ Stop date:_____

Student may carry (if applicable to school protocol) and self medicate: Yes_____ No_____

List significant side effects: _____

Physician Printed name: _____

Physician signature:_____Date:_____

Facility Name and Phone: _____

(PLEASE USE ONE FORM FOR EACH MEDICATION)