



MATIGNON HIGH SCHOOL

Permission for Medication Distribution by the School Nurse

For students requiring prescription medications, including Epi-pens and Albuterol

Students who have a condition or allergy that requires medications to be given at school will need to deliver the medication (in the original packaging with the prescription label attached) and a Physician permission form (please see reverse side) in order for the nurse to be able administer the medication. This includes Epi-pens, albuterol, and any other prescription medications. This process needs to be done at the beginning of every school year per the regulations of the Department of Public Health. **Students who have an albuterol inhaler or an Epi-pen will not be allowed to participate in fields trips unless these medications and documentation are on file with the Nurse's Office.**

For all students, Permission to administer Tylenol, Ibuprofen, or Benadryl

Students Name: _____ Date of Birth: _____

Grade level in September 2018: _____ Allergies: _____

List other medications student is currently taking: _____

I give permission for the School Nurse to administer the following medications to my son/daughter:

Acetaminophen (Tylenol)	Yes	No
Ibuprofen (Motrin)	Yes	No
Diphenhydramine (Benadryl)	Yes	No

Parent/Guardian Signature: _____

Printed Name: _____ Date: _____

Please return this form to the School Nurse, Kathy Clark, RN
Telephone: (617) 876-1212 x23 Fax: (617) 661-3905
Email: kclark@matignon.org



MATIGNON HIGH SCHOOL

Physician Permission Form for Prescription Medications

Medications should be delivered to the school nurse, in their original packaging with the pharmacy label and directions attached to the package. Medications must not be expired or expired before June 2018. Students who have an albuterol inhaler or an Epi-pen will not be allowed to participate in fields trips unless these medications and documentation are on file with the Nurse's Office.

Student Name: _____ DOB: _____

Reason for medication: _____

Allergies: _____

TO BE FILLED OUT BY PHYSICIAN

Medication: _____ Dose: _____

Route: _____ Frequency: _____

Date of order: _____ Discontinue: June 15, 2019

Medication: _____ Dose: _____

Route: _____ Frequency: _____

Date of order: _____ Discontinue: June 15, 2019

Medication: _____ Dose: _____

Route: _____ Frequency: _____

Date of order: _____ Discontinue: June 15, 2019

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