DIMAN REGIONAL VOCATIONAL TECHNICAL HIGH SCHOOL
FALL RIVER • SOMERSET • SWANSEA • WESTPORT
251 Stonehaven Road, Fall River, MA 02723
TEL: 508-678-2891 • FAX: 508-674-3263

AUTHORIZATION FOR DISPENSING MEDICATION_____

PARENT OR GUARDIAN

I request that my son/daughter _____

D.O.B. ___/____/_____ ID# _____ Grade _____ Shop _____

A student at Diman Regional Vocational Technical High School receive/be allowed to take the following medications as prescribed by Dr. _____ in the form below.

The medicine is to be furnished by me as designated in the medication policy of Diman Regional Vocational Technical High School.

I understand that the school is rendering a service and does not assume any responsibility in this matter.

Signature _____ Date__/____/_____

Home Phone # _____-____-_____ Daytime # _____-____-_____ Cell # _____-____-_____

Whenever possible, medication should be administered at home and every effort should be made to avoid school hours.

PHYSICIAN

I request that my patient receive/be allowed to take the following medication:

Name of Student _____ Diagnosis _____

Name of Medication(s) _____

Prescribed Dosage _____

Time and method to be taken during school hours _____

Expected duration of treatment _____

Possible side effects and adverse reactions _____

_____

Other Recommendations _____

Student: Self-Administer ❑Yes ❑No Student: Self Carry ❑Yes ❑No

Signature _____ Name (please print) _____

Date _____ Phone # _____