

South Shore Educational Collaborative

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AUTHORIZATION FOR DISPENSING MEDICATION IN SCHOOL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS

PARENT/GUARDIAN

I hereby request that my child _____ Grade _____

Receive the following medication: _____

Prescriber's Name _____ Phone # _____

Parent/Guardian Signature _____ Date _____

PHYSICIAN

I request that my patient receive the following medication(s) during school: _____

Name of Student _____ Diagnosis _____

Reason for Medication _____

Prescribed Dosage _____

Time to be taken during school _____

For PRN medication please indicate how often to administer _____

Other medications being taken by the student _____

Possible side effects and adverse reactions _____

Prescriber's Signature _____ Date _____

Prescription end date: _____ (by 6/30 of school year unless otherwise specified)

Rev 5/7/21 PA

The South Shore Educational Collaborative serves Braintree, Cohasset, Hingham,
Hull, Marshfield, Milton, Norwell, Quincy, Randolph, Scituate, Weymouth and Whitman Hanson R.S.D.