Massachusetts Department of Public Health School Health Unit and Massachusetts Controlled Substance Registration (MCSR) Signature Page

I hereby attest that as the **School Nurse Manager (RN)**, I have completed this application and understand my roles as manager and supervisor of the medication storage, handling and delegation program in the applicant school system / school. I will act as the Massachusetts Department of Public Health contact on all matters relating to the administration of medications in the school setting. I have developed and/or reviewed the policies and procedures in compliance with regulations105 CMR 210.000 in consultation with the school physician and have recommended to the School Committee/Board of Trustees adoption of the policies.

____________________	____________________	__________
Medication Manager (RN) (*Signature /Credentials)*	Medication Manager (RN) (Please Print)	Date

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School Name and Address of Medication Manager (RN)　City　State　Zip Code

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Telephone Number	E-mail Address	RN License Number

I hereby attest that as **School Physician (MD),** I have consulted with the Medication Manager (RN) in the preparation of this application. I have reviewed the regulations, policies and procedures and have recommended to the School Committee/Board of Trustees adoption of the policies.

____________________	____________________	__________
School Physician (MD) (*Signature)*	School Physician (MD) (Please Print)	Date

I hereby attest that as **Superintendent of Schools or Administrator of the School,** I agree with the intent of the regulations and with the policies as specified in this application. I thus acknowledge the Medication Manager (RN) management role and responsibility as defined in regulations 105 CMR 210.000. I have reviewed the regulations, policies and procedures and have recommended to the School Committee/Board of Trustees adoption of the policies.

____________________	____________________	__________
Superintendent of Schools or Administrator of School (*Signature)*	Superintendent of Schools or Administrator of School (Please Print)	Date

I hereby attest that as **Chair, School Committee** or **Chair, Board of Trustees**, the Committee/Board has agreed to adopt the policies and procedures governing the administration of prescription medications as defined by statute and regulation (M.G.L. 94C and 105 CMR 210.000). The School Committee/Board of Trustees has approved the categories of unlicensed personnel who may administer prescription medications and understands the Medication Manager (RN) role as manager of the medication program in the school.

____________________	____________________	__________
Chair, School Committee or Chair, Board of Trustees (*Signature)*	Chair, School Committee or Chair, Board of Trustees (Please Print)	Date