Parent/Guardian Consent for Administration of Medication and Medication Administration Plan

Student's Name:_____DOB:_____
Address:_____Grade:_____
Parent/Guardian Names: #1_____ #2_____
Home Phone No._____ #2_____
Cell Phone No._____ #2_____
Work Phone No._____ #2_____

Other person(s) to be notified in an emergency if the parent/guardian is unavailable:
Name(s): _____
Phone #_____Relationship:_____

Name of licensed prescriber:_____Phone number:_____

Please list all medications your child is currently receiving (if not in violation of confidentiality):

_____

My son/daughter has the following food or drug allergies. (Please specify past-reaction):

_____

Diagnosis (if not in violation of confidentiality):_____

I give permission for the school nurse/school personnel designated by the school nurse to administer the following medication:
Medication name:_____
Amount:_____Route:_____Time to be given:_____

I give permission for my son/daughter to self-administer the medication, if the school nurse determines it safe and appropriate.
Yes_____ No _____

I give permission for the school nurse to share information relevant to this medication as she determines necessary for my son's/daughter's health and safety.

I understand that the medication must be delivered to school health office by a responsible adult, in a properly labeled pharmacy container. Also, the medication must be accompanied by a medical provider medication order. I will supply a picture of my child. I understand that I may retrieve the medication from the school nurse at any time; however, the medication will be destroyed if it is not picked up within one week following the termination of the order or one day beyond the close of the school year.

The following is to be completed with the school nurse:
Duration of order:_____to_____Expiration date of medication received:_____
Possible side effects/adverse reaction:_____
Location/storage of medication:_____
Plan for field trips:_____Delegated to:_____
Plan for monitoring medication:_____
Plan for teaching self administration with prescriber and parental consent:_____
_____Date of self-medication observation:_____

Parent/Guardian signature:_____Date:_____
School Nurse signature:_____Date:_____
Student signature (if applicable:_____ Date:_____

MEDICATION ORDER

(To be completed by a Licensed Prescriber:
Physician, Nurse Practitioner or others authorized by Chapter 94C)

Name of Student: _____ Date of Birth: ____/____/____

Address: _____ Grade: _____

Name of Licensed Prescriber: _____ Title: _____
Business Telephone Number: _____
Emergency Telephone Number: _____

Medication: _____

Dosage: _____ Route of Administration: _____

Frequency: _____ Time(s) of Administration in school: _____
(Please note: Whenever possible, medication should be scheduled at times other than school hours)

Specific directions or information for administration: _____
_____

Date of Order: _____ Discontinuation Date: _____

Diagnosis*: _____

Allergy: _____

Any other medical condition(s)*: _____

Consent for the self-administration (Provided the school nurse determines it is safe and appropriate). Yes ☐ No ☐

ADDITIONAL INFORMATION

1. Specific side effects, contraindications, or possible adverse reactions to be observed:
   _____
2. *Other medications being taken by the student: _____
   _____
3. Date of the next scheduled visit or when advised to return to prescriber: _____

Signature of Licensed Prescriber: _____
Date: _____

*If not in violation of confidentiality