



Medication Administration in School Consent/Physician's Orders

LICENSED PRESCRIBER ORDER

(To be completed by Physician, Nurse Practitioner, or other provider authorized by Chapter 94C)

Student \_\_\_\_\_ DOB \_\_\_\_\_ Grade/Room \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Allergies: \_\_\_\_\_

Table with 5 columns: Medication, Dose, Route, Frequency, Time. Rows 1, 2, 3.

Possible side effects: \_\_\_\_\_

Student may self-administer inhaler, EpiPen, & insulin if School Nurse determines it is safe and appropriate YES \_\_\_ NO \_\_\_

NOTE: Whenever possible, medication should be given at home to avoid school hours

Prescriber's Print \_\_\_\_\_ Phone \_\_\_\_\_

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*

PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

I give permission for the School Nurse to administer the following medicine(s) to my child \_\_\_\_\_

Drug \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_

Drug \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_

Drug \_\_\_\_\_ Dose \_\_\_\_\_ Time \_\_\_\_\_

Permission for teacher/designated adult to administer medication(s) (excluding psychotropics, diabetic) during field trips YES \_\_\_ NO \_\_\_

Permission to share pertinent medication information with appropriate school personnel:..... YES \_\_\_ NO \_\_\_

Permission to self-administer if the School Nurse determines it is safe and appropriate:..... YES \_\_\_ NO \_\_\_

Medication must be delivered by a responsible adult in a labeled original pharmacy container(s). I understand that the school may store only a 30 day supply of controlled medication.

I understand that all medications will be destroyed if not picked up by the last day of school.

Parent / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Phones: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_