MEDICATION ORDER

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

Name of Student_____ Date of Birth_____

Address_____ Grade _____
(street) (city/town)

Name of Licensed Prescriber_____ Title_____

Business Telephone Number_____
Emergency Telephone Number_____

Medication _____

Route of Administration_____Dosage_____

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

Specific directions or information for administration:_____

Date of Order _____Discontinuous Date _____

Diagnosis _____

Consent for self-administration (provided the school nurse determines it is safe and appropriate).
Yes_____ No_____

_____
Signature of Licensed Prescriber

PARENTAL CONSENT

1. I give permission to have the school nurse or school personnel designated by the school nurse give the following medicine _____
(Name of medication and dose)

   prescribed by _____ to _____
(Licensed Prescriber) (Name of Student)

2. I give permission for my son/daughter to self administer medication if the school nurse determines it is safe and appropriate. Yes_____ No_____

3. I give permission to the school nurse to share with the appropriate school personnel information relative to the prescribed medication administration, e.g., adverse side effects, as she/he determines necessary for my son's/daughter's health and safety.

   Yes _____ No _____ Any restriction on release _____

4. Daily meds and emergency meds and inhalers will be sent on Field Trips and administered by designated school personnel: Yes_____ No_____

(Please note: I understand that I may retrieve the medicine from the school at any time and that the medicine will be destroyed if it is not picked up within one week following the termination of the order or one week beyond the close of school.)

Signature of Parent/Guardian _____

Relationship to Student _____ Date _____