BRITISH INTERNATIONAL SCHOOL OF BOSTON
A NORD ANGLIA EDUCATION SCHOOL

Prescribed Medication Order: 2024-2025 Academic Year

(To be completed/signed by a Licensed Prescriber & signed by Parent/Guardian)

This form covers the administration of prescription medication in school (e.g. inhaler, Epi-Pen, etc.). According to Massachusetts law and for the safety of all students, ALL medications MUST be delivered to the school nurse or school staff member IN THE ORIGINAL CONTAINER by a parent/guardian.

Student Name:_____**Year:**_____**Date of Birth:** _____

Name and Title of Licensed Prescriber: _____

Business Phone: _____**Emergency Phone:** _____

Medication:_____

Dosage: _____**Route**:_____

Frequency: _____**Time(s) of Administration:** _____

(*Please note: Whenever possible, medications should be scheduled at times other than school hours.*)

Specific Directions or information for Administration:

_____

Date of Order: _____**Discontinuation Date**: _____

***Diagnosis:**_____

***Any other medical conditions**_____

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

Yes: _____**No:** _____

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Special side effects, contradictions, possible adverse reactions:

_____

Other medications being taken by the student:

_____

Date of return visit (if applicable): _____

Signature of Licensed Prescriber: _____ Date:_____

Signature of Parent / Guardian: _____ Date:_____

*If not in violation of confidentiality