Prescribed Medication Order: 2023-2024 School Year

(To be completed by a Licensed Prescriber)

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**: _____ **(this order will expire no later than 7/9/24)**

***Diagnosis:**_____

***Any other medical conditions:**_____

Consent for self-administration (provided the school nurse determines it is safe and appropriate) Yes: _____ **No:** _____

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:** _____

*If not in violation of confidentiality

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Parent/Guardian Authorization for Prescription Medication Administration: 2023-2024 School Year
(To be completed by the Parent/Guardian)

Student's Name: _____

Parent/Guardian *Printed* Name: _____

Telephone number—Home: _____

Telephone number—Work: _____

Telephone number—Cell: _____

Other person(s) to be notified in case of medication emergency:

Name: _____Telephone number: _____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality):

My son/daughter has the following food or drug allergies:

I consent to have the school nurse or school personnel designated by the School Nurse administer the medication prescribed by:

_____ to _____
Licensed Prescriber's Name Student's Name

I give permission for my son/daughter to self-administer medication, if the school nurse determines it is safe and appropriate.
_____Yes ____No

I give permission to the School Nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.
_____Yes ____No

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Parent/Guardian Signature_____Date: _____

Relationship to Student_____

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