Medication Order

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

Name of Student__________________________________ Grade_______________

Address____Date of Birth__________
(Street) (City/town/zip)

Name of Licensed Prescriber________________________________Title________
Business Telephone #____________________Emergency Telephone #__________

Medication____
Route of administration________________ Dosage_________________________
Frequency__________________________Times 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______________________ Discontinuation date_____________________

Diagnosis*____

Any other medical condition(s)____

Optional Information

1.) Special side effects, contraindications, or possible adverse reactions to be observed____
____

2.) Other medication being taken by the student
____
____

3.) Date of the next scheduled visit or when advised to return to provider__________

4.) Consent for self administration (provided the School Nurse determines it is safe and appropriate).____________Yes _______________No

____
Signature of Licensed Prescriber

* If not in violation of confidentiality

Written Parent / Guardian Consent For Medication Administration

General information- Please print

Name of Student____Grade_______

Date of Birth:_________________Sex_______ School: Pentucket Regional High School

Name of Parent/Guardain:____

Address: ____

Telephone # Home:__________________ Work:______________Cell:______________

Telephone # where parent/guardian may be reached in case of Emergency ____________

Other persons, if nay, to be notified in case of emergency if parent/guardian is unavailable: Name: ___________________________Relationship:_________________

Telephone #____

My son/daughter is currently receiving the following medication(s) (to be completed if not in violation of confidentiality- please list all medications the child is receiving, including those given during the school day):

1.)__________________________________ 2.)________________________________

3.)__________________________________ 4.) ________________________________

My son/daughter is known to have the following allergies: ____

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Consent

1.) I give permission for the School Nurse, or school personnel designated by the School Nurse, to give the following medication ______________________________________

(Name of Medication)

____________________________________ 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 appropriate school personnel information relative to the prescribed medication administration (e.g., adverse side effects) as she/he deems it necessary for my child's health and safety.

Yes__________ No____________ Any restrictions on release____________________

(Please note: I understand that I may retrieve the medicine from school at any time and that the medicine 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______