



**Parent/Guardian Consent for Administration of Medication and Medication Administration Plan**

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ Grade: \_\_\_\_\_  
Parent/Guardian Names: #1 \_\_\_\_\_ #2 \_\_\_\_\_  
Home Phone No. \_\_\_\_\_ #2 \_\_\_\_\_  
Cell Phone No. \_\_\_\_\_ #2 \_\_\_\_\_  
Work Phone No. \_\_\_\_\_ #2 \_\_\_\_\_

Other person(s) to be notified in an emergency if the parent/guardian is unavailable:

Name(s): \_\_\_\_\_  
Phone # \_\_\_\_\_ Relationship: \_\_\_\_\_

Name of licensed prescriber: \_\_\_\_\_ Phone number: \_\_\_\_\_

Please list all medications your child is currently receiving (if not in violation of confidentiality):

My son/daughter has the following food or drug allergies. (Please specify past-reaction):

Diagnosis (if not in violation of confidentiality): \_\_\_\_\_

I give permission for the school nurse/school personnel designated by the school nurse to administer the following medication:

Medication name: \_\_\_\_\_  
Amount: \_\_\_\_\_ Route: \_\_\_\_\_ Time to be given: \_\_\_\_\_

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

Yes \_\_\_\_\_ No \_\_\_\_\_

I give permission for the school nurse to share information relevant to this medication as she determines necessary for my son's/daughter's health and safety.

I understand that the medication must be delivered to school health office by a responsible adult, in a properly labeled pharmacy container. Also, the medication must be accompanied by a medical provider medication order. I will supply a picture of my child. I understand that I may retrieve the medication from the school nurse at any time; however, the medication will be destroyed if it is not picked up within one week following the termination of the order or one day beyond the close of the school year.

**The following is to be completed with the school nurse:**

Duration of order: \_\_\_\_\_ to \_\_\_\_\_ Expiration date of medication received: \_\_\_\_\_  
Possible side effects/adverse reaction: \_\_\_\_\_  
Location/storage of medication: \_\_\_\_\_  
Plan for field trips: \_\_\_\_\_ Delegated to: \_\_\_\_\_  
Plan for monitoring medication: \_\_\_\_\_  
Plan for teaching self administration with prescriber and parental consent: \_\_\_\_\_  
Date of self-medication observation: \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

School Nurse signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student signature (if applicable): \_\_\_\_\_ Date: \_\_\_\_\_

### MEDICATION ORDER

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

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ Grade: \_\_\_\_\_

Name of Licensed Prescriber: \_\_\_\_\_ Title: \_\_\_\_\_

Business Telephone Number: \_\_\_\_\_

Emergency Telephone Number: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Route of Administration: \_\_\_\_\_

Frequency: \_\_\_\_\_ Time(s) of Administration in school: \_\_\_\_\_

(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\*: \_\_\_\_\_

Allergy: \_\_\_\_\_

Any other medical condition(s)\*: \_\_\_\_\_

Consent for the self-administration (Provided the school nurse determines it is safe and appropriate). Yes  No

#### ADDITIONAL INFORMATION

1. Specific side effects, contraindications, or possible adverse reactions to be observed:

2. \*Other medications being taken by the student: \_\_\_\_\_

3. Date of the next scheduled visit or when advised to return to prescriber: \_\_\_\_\_

Signature of Licensed Prescriber: \_\_\_\_\_

Date: \_\_\_\_\_

\*If not in violation of confidentiality