IN ORDER FOR THE SCHOOL NURSE TO ADMINISTER ANY MEDICATION, THIS FORM MUST BE COMPLETED BY BOTH A PHYSICIAN AND A PARENT, AND PRESENTED ON THE FIRST DAY OF SCHOOL.

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_____
(street) (city/town)

Name of Licensed Prescriber_____ Title_____

Business Telephone Number_____

Emergency Telephone Number_____

Name of Medication_____

Route of Administration_____ Dosage_____

Frequency_____ Time(s) of Administration_____

Specific Directions or Information for Administration_____

Date of Order_____ Discontinuation Date_____

Diagnosis_____

Consent for Self-Administration (Provided the 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 staff designated by the nurse to give the

   following medicine_____ prescribed by_____
   (Name of Medicine) (Licensed Prescriber)

   to_____.
   (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 faculty/staff personnel information relative to the prescribed medicine administration, e.g., adverse side effects, as he/she determines necessary for my son's/daughter's health and safety.

   Yes_____ No_____ Any restrictions on release_____

(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 by the end of each school year.)

Signature of Parent/Guardian_____Date_____