Westford Public Schools

MEDICATION ADMINISTRATION ORDERS, CONSENT, AND PLAN OF CARE

Name:_____Grade:_____D.O.B._____
Name of Licensed Prescriber: _____School: _____ Sex: M / F
Diagnosis: _____
Food Drug Allergies: _____
Medication: _____Dosage:_____Frequency:_____
Possible Side Effects: _____
Is it absolutely necessary for this medication to be taken at school? Y / N
Date of Order: _____Expiration of Order: _____ Expiration of Medication: _____
Quantity of medication received by the school nurse and date: _____

To be completed if not in violation of confidentiality:
Please list all medications the child is receiving, including those given during and after school hours.
Please include adverse reactions and side effects.

_____

Signature of Physician: _____ Date: _____

PARENTAL CONSENT

(Please initial)

____Student should always take medication on a field trip.

____Student can miss the medication on field trip days.

____The school nurse may administer the medication ordered above.

____Student may self-administer medication (such as inhalers) at school **and/or** field trips.

____The school nurse may share with appropriate school personnel, information relative to the prescribed medication administration. (e.g. adverse side effects as the nurse determines necessary for the student's health and safety.)

____A teacher or chaperone deemed qualified by the school nurse may administer this medication on field trips.

Please list any emotional response and/or need for support: _____

***Please note**:* I understand that I may retrieve the medication from the school at any time, and that the medicine will be destroyed if it is not picked up following termination of the order.
I understand that **an adult** must bring all psychotropic medications (i.e. meds for ADD) to school and that my student may not carry these medications on the bus.

Parent/Guardian (please print):_____

Signature of Parent/Guardian:_____

Relationship to Student:_____ Date:_____

sjp 5/08