

DUDLEY-CHARLTON REGIONAL SCHOOL DISTRICT

Medication Order

(to be completed by Physician, Nurse Practitioner or others as authorized by Chapter 94C)

Name of Student: _____ DOB: _____
(Please Print)

Address: _____
(Street) (City/Town) (Zip)

Emergency Telephone: _____ Work Telephone: _____

Name of Licensed Prescriber: _____

Diagnosis*: _____
*if not in violation of confidentiality

Medication: _____ Dosage: _____

Frequency/Time: _____
(whenever possible, medication should be scheduled at times other than school hours)

Date of Order: _____ Discontinuation Date: _____

Any Other Medical Condition(s): _____

Optional Information

1. Special side effects, contraindications, or possible adverse reactions: _____

2. Other medication taken by student: _____

3. The date of the next scheduled visit or when advised to return to prescriber: _____

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

Signature of Licensed Prescriber

DUDLEY-CHARLTON REGIONAL SCHOOL DISTRICT

Written Parent/Guardian

Consent for Medication Administration

General Information

Name of Student: _____ Date of Birth: _____

School: _____ Grade: _____

Name of Parent/Guardian: _____

Address: _____

Home Telephone#: _____ Work Telephone#: _____

Please note any other medication the child is currently receiving: _____

Please note any allergies: _____

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Consent

1. I give permission to have the school nurse or school personnel designated by the school nurse give the following medicine:

Name of Medication: _____

Physician: _____

2. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medicine administration (e.g., adverse side effects) as she/he 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 within one week beyond the close of school.)

Signature of Parent/Guardian: _____

Relationship to Student: _____ Date: _____