Dear Parent/Guardian:

We would like to inform you of the policies that have been put in place to ensure the health and safety of children needing medicines during the school day.

Our school district requires that the following forms must be on file in your child's health record before we begin to give any medicine at school:

1. Signed consent by the parent or guardian to give the medicine. Please complete the enclosed consent form and give it to your school nurse.

2. Signed medication order. The written medication order form should be taken to your child's licensed prescriber (your child's physician, nurse practitioner, etc.) for completion and returned to the school nurse. This order must be renewed as needed and at the beginning of each academic year.

Medicines should be delivered to the school in a pharmacy or manufacturer-labeled container by you or a responsible adult whom you designate. Please ask your pharmacy to provide separate bottles for school and home. No more than a thirty-day supply of medicine should be delivered to the school.

When your child needs a medicine to be given during the school day, please act quickly to follow these policies so we may begin to give the medicine as soon as possible. If you have any questions please call (978) 454-5411 Ext. 4411, 4422, 4433 or 4455. Forms may be faxed to (978) 441-5336.

School Nurses

# MEDICATION ORDER FORM

(to be completed by a licensed prescriber)

Name of Student:_____ Date of Birth:_____

Address:_____ Grade:_____
(street) (city/town)

Name of Licensed Prescriber _____ Title:_____

Business Phone:_____ Emergency Phone:_____

Medication:_____

Route of administration:_____ Dosage:_____

Frequency _____ Time(s) 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 medications being taken by the student: _____
   _____
3. 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

*if not in violation of confidentiality.

# NURSING PRACTICE IN THE SCHOOL SETTING

## Parent/Guardian Authorization for Prescription Medication Administration

Student's Name: _____ Date of Birth: _____

Parent/Guardian (print name): _____

Home Phone: _____ Work Phone: _____

Emergency Contact(s): Name: _____ Phone: _____

Name: _____ Phone: _____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality). _____

My son/daughter has the following food and drug allergies: _____
_____

I consent to have the school nurse or school personnel designated by the school nurse administer the medication prescribed by:

_____to_____
Licensed Prescriber Student's Name

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

____Yes ____No

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

I understand I may retrieve the medication from the school at any time; *however, the medication 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:_____

Relationship to Student:_____

Address:_____

_____