Ralph C. Mahar Regional School District

507 South Main Street
P.O. Box 680
Orange, Massachusetts 01364-0680

Telephone (978) 544-2542 **Fax (978) 544-5844**

MEDICAL & HEALTH DEPARTMENT

School Year Medication Form

We would like to inform you of the policies that have been put in place to ensure the health & safety of children needing medicines during the school day. Our school district, in compliance with state regulations, requires that the following information is on file in your child's health record in order for your child to be given ANY medication at school: **Signed consent by the parent/guardian AND a signed medication order by the appropriate licensed prescriber/medical provider.**

Medications should be delivered to the school in a pharmacy or manufacturer-labeled container by you or a responsible adult. No more than a 30 day supply of the medicine should be delivered to the school.

Student's name:_____Birth date:_____Grade:_____
Address:_____

Parent/Guardian printed name:_____Telephone number:_____
Please print
Please list any allergies (food, drug, seasonal, insect bites/stings)_____
_____ _

Name of Medication:_____Dosage:_____Frequency:_____

I consent to have the school nurse administer the prescribed medication: YES_____ NO_____
I give permission to the school nurse to share information relevant to the prescribed medication administration as she determines appropriate for my child's health & safety: YES_____ NO_____

Parent/Guardian signature:_____Date:_____

Please have your medical provider FAX (978-544-5844) the medication information as listed below:

Licensed Prescriber/Medical Provider please complete the information below:

Printed name of licensed prescriber:_____Telephone:_____

Medication:_____Dosage:_____Route_____

Frequency:_____Time(s) of Administration:_____
Duration of order (not to exceed July 1st):_____
Medication orders MUST be renewed at the beginning of each school year.
Licensed Prescriber's signature:_____Date:_____
Special side effects, contraindications, or possible adverse reactions to be observed? YES_____ NO_____
Please provide parameters for which you would like to be notified of:_____
_____

Thank you, Susan Jillson, BSN, RN, School Nurse, ***978-544-2542 #5 (ext. 220) fax 978-544-5844***