Wachusett Regional School District

Holden, Paxton, Princeton, Rutland, Sterling

Medication Administration Order and Administration Plan

Student Name:_____**DOB:**_____**School:**_____**Grade:**____ **HR** _____**Year**_____

To Be Completed by the Physician (Order may be attached to this form)

Known Food/Drug Allergies:_____

Diagnosis Related to this Prescription:_____

Name of Medication:_____ **Date Ordered:**_____ **Duration of Order:**_____

Dose:_____**Frequency:**_____**Route:**_____**Dose Time:**_____

Special Storage Instructions:_____

Side Effects/ monitoring requirements if needed:_____

Other Medications being taken by student:_____(If not in violation of confidentiality)

Physician Name:_____**Physician Phone:**_____

Physician Signature:_____**Date:**_____

To Be Completed by the Parent/Guardian

Parent/Guardian Permissions:

- ☐ I give the school nurse permission to administer this medication to my child
- ☐ The school nurse may consult my child's physician about administering this medication to my child.
- ☐ I understand that it is my responsibility to pick up this medication when it is no longer needed at school.
  - ★ *Please note that noontime/lunch medications will not be given on early release days without a written note from parent/guardian*

Field Trip Plan: When there is a field trip, this medication will be :

- ☐ Given by Nurse **AND/OR**
- ☐ Given by designated unlicensed trained school personnel on field trips **AND/OR**
- ☐ Self-Administered by student, with nurse approval per state mandate (only medications administered in school)
  - ★ *Self Administration Medication Authorization Form must be completed and attached.*

Emergency contact (if parent is not available):_____ **Phone Number:** _____

Parent/Guardian Printed name:_____**Phone Number:**_____

Parent/Guardian Signature:_____**Date:**_____

Medication Administration Plan: To Be Completed By the School Nurse

Location where medication administration will occur: _____

Initial quantity of Medication Received by School:_____Date Received:_____

Self Administration Authorization Form Completed: _____

Delegated to (if applicable): _____ Back-Up Delegate:_____

Approved: YES NO	**Nurse Signature:**	**Date:**