ESSEX NORTH SHORE
AGRICULTURAL & TECHNICAL SCHOOL

MEDICATION ADMINISTRATION PLAN

School Year 2025-26

CAREGIVER CONSENT

Student Name: _____ DOB:_____Grade: _____

Caregiver Name: _____ Telephone: _____

Relationship to Student: _____

Medication Name and Dosage: _____

Specific Directions, e.g. times to be given: _____

Will this medication be taken daily at school: YES ❑ NO ❑

Is this medication required on field trips? YES ❑ NO ❑

Part A. **If the student requires <u>any</u> prescription medication while at school or on field trips, please read below:**

School staff will hold all medication, except for EpiPens, inhalers, and certain enzymes, which students may keep with them..
Note: *Staff recommend that inhalers and EpiPens also be kept in the health office when possible.*

1. **Required:** Please have the Physician fax or email all medication orders to 978-304-4619 or nurse@essextech.net
2. I authorize the student to self-administer this medication, with nurse approval. YES ❑ NO ❑
3. **If you answered <u>NO</u> to question 2:** I authorize the nurse or delegated, trained staff member to carry **and** administer the prescribed medication. YES ❑ NO ❑

Part B. **For students with diabetes or a diagnosed seizure disorder:**

I understand and acknowledge that the administration of emergency diabetes and seizure medication cannot be delegated to any staff member. I understand that in the event of a diabetic emergency or seizure, Emergency Medical Services will be contacted immediately. YES ❑ NO ❑

I understand that I must deliver the medication in the pharmacy or manufacturer's package to the Nurse. I also understand that I may retrieve the medication at any time and that it will be destroyed if it is not picked up within one week following the termination of the order or by the end of the day on the last day of school.

Caregiver Signature _____ Date _____

For Nurse use only: I attest that all required health information has been reviewed for this student. The student has been assessed and approved to self-administer the above named medication. YES ❑ NO ❑ N/A ❑

Nurse Signature_____Date_____

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PHYSICIAN/PROVIDER ORDER

to be completed by a licensed prescriber

Student Name: _____ DOB: _____

*Medication: _____ Dosage: _____ Route: _____

Frequency/Time: _____ Start Date:_____ to _____

Diagnosis (if not confidential): _____

_____

Special instructions and storage considerations: _____

_____

Possible side effects or adverse reactions: _____

_____

Physician's Name: _____ Date: _____

Physician's Signature:_____ Telephone: _____

***For emergency medications (e.g., albuterol inhaler and/or epinephrine) ONLY**

Student may carry & self-administer their inhaler and/or epinephrine at school and/or on field trips: YES ❑ NO ❑

HEALTH OFFICE CONTACT INFORMATION

978.304.4700 x3118 | FAX #: 978.304.4619 | nurse@essextech.net

BEVERLY | BOXFORD | DANVERS | ESSEX | GLOUCESTER | HAMILTON | LYNNFIELD
MANCHESTER | MARBLEHEAD | MIDDLETON | NAHANT | PEABODY | ROCKPORT | SALEM
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