Framingham PUBLIC SCHOOLS
Department of Health & Wellness

Medication Administration in School Consent/Physician's Orders

LICENSED PRESCRIBER ORDER

(To be completed by Physician, Nurse Practitioner, or other provider authorized by Chapter 94C)

Student_____**DOB**_____**Grade/Room**_____

Diagnosis:_____**Allergies:**_____

Medication	**Dose**	**Route**	**Frequency**	**Time**
1.				
2.				
3.				

Possible side effects:_____

Student may self-administer inhaler, EpiPen, & insulin if School Nurse determines it is safe and appropriate
YES___NO___

NOTE: ***Whenever possible, medication should be given at home to avoid school hours***

Prescriber's Print_____Phone_____

Prescriber's Signature_____Date_____

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PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

I give permission for the School Nurse to administer the following medicine(s) to my child _____

Drug_____Dose_____Time_____
Drug_____Dose_____Time_____
Drug_____Dose_____Time_____

Permission for teacher/designated adult to administer medication(s) (excluding psychotropics, diabetic) during field trips YES_____NO_____
Permission to share pertinent medication information with appropriate school personnel:.....YES_____NO_____
Permission to self-administer if the School Nurse determines it is safe and appropriate:.....YES_____NO_____

Medication must be delivered by a responsible adult in a labeled original pharmacy container(s). I understand that the school may store only a 30 day supply of controlled medication.

I understand that all medications will be destroyed if not picked up by the last day of school.

Parent / Guardian Signature_____Date_____

Phones: Home_____Work_____Cell_____