RVCS Combined Medication Receipt and Medication Administration Plan

Name of Student_____ Grade _____

Date of Birth_____ Food/Drug Allergies _____

Parent/guardian name and contact number _____

Diagnoses:_____ (if not a violation of confidentiality)

At River Valley Charter School safety is our priority. For every medication to be given routinely in school, a medication receipt form, plan for administration, and complete medication order must be obtained. Medication will only be administered if it arrives with the pharmacy label intact, or in its original OTC packaging. In accordance with MDPH, the medication order shall originate from the prescriber and shall include the following:

- Student's Name
- Name and signature of licensed prescriber, and their phone number(s)
- Name, Route, and Dosage of Medication
- Date of Order
- Diagnosis
- Any additional specific directions for administration of medication
- Frequency and time of medication administration

Possible Side Effects, Adverse Reactions: _____

Medication, Dose, and Quantity Received _____ _____

Delegated to (if applicable): _____

Back-up Plans (if delegatee unavailable):_____

Plan for Field Trips: _____

Plans for teaching self administration, if applicable: _____

Location where medication will be stored/administered: ___Health Office ___Other (specify) _____

Plan for monitoring medication, if needed: _____

Receiving School Nurse Signature and date _____

By signing below I agree that the above described medication will be dispensed ACCORDING TO PHYSICIAN'S ORDERS. I understand that a nurse may not administer a different dose or different medication without a new order from a physician. I understand that physician's medication orders expire after one year, but that specific medications may expire earlier depending upon the date manufactured and the shelf life of the medication. Volume received may not exceed a 30 day supply.

In addition, per 105 CMR 210.005(H): In accordance with standard nursing practice, the school nurse may refuse to administer or allow to be administered any prescription medication which, based on her/his individual assessment and professional judgment, has the potential to be harmful, dangerous or inappropriate. In these cases, the parent/guardian and licensed prescriber shall be notified immediately by the school nurse.

My signature below may be used as consent for the administration of medication, as described above.
Parent/Guardian Signature and date _____
Student's Signature and date, if appropriate_____

Adapted from MDPH October 2024
https://www.mass.gov/lists/school-health-services-sample-policies-and-forms#medication-administration-plan-and-daily-log-