Benjamin Franklin Classical Charter Public School
KNOWLEDGE • CHARACTER • RESPONSIBILITY • COMMUNITY

500 Financial Park - Franklin, Massachusetts 02038 | 508.541.3434 | BFCCPS.org

Medication Order Form
Completed by Licensed Prescriber – One Per Medication

******The prescribing physician may also choose to FAX a medication order to the Health Office in lieu of completing the upper portion of the form below although the parental permission portion still must be completed.******

Student Name: _____ **Birthdate:** _____ **Grade:** _____
Print

Diagnosis: _____

Medication: _____ **Dosage:** _____

Route: _____ **Frequency:** _____

Specific Directions: _____

Date of Order: _____**Discontinue Date:** _____

Special side effects, contraindications or possible adverse reactions to be observed for:
_____
_____

Other medical conditions: _____**Allergies:** _____

_____ _____
Signature of Provider **Date** **Print Name of Provider** **Phone**

Written Parent/Guardian Consent

_____ _____
Name of Student & Date of Birth **Name of Parent/Guardian (Print) & Phone Number**

- **I give my permission to the school nurse, or her designee, to give the following medication(s)_____ to my child.**
- **I give the school nurse permission to share information relative to the prescribed medication with appropriate school personnel: Yes _____ No _____**
- **I give my permission for my child to self-administer his/her own medication, provided the school nurse determines it is safe and appropriate: Yes _____ No _____**
- **My child has the following allergies:**
  _____

I understand that I may retrieve the medicine from school at any time and that the medicine will be destroyed if it is not picked up within one week following discontinuation of the order or one week beyond the close of school.

_____ _____
Parent/Guardian Signature **Date**