

Watertown School Health Services

MEDICATION ORDER

(To be completed by a Licensed Prescriber, Physician, Nurse Practitioner, other authorized by Chapter 94C)

Name of student _____ Date of birth _____

Address _____ Grade _____

Name of Licensed Prescriber _____ Title _____

Business telephone number _____

Fax number _____ Emergency phone number _____

Medication (must be delivered in the original container/box) _____

Route of administration _____ Dosage _____

Frequency _____ Time(s) of administration _____
(Please note: Whenever possible, medication should be scheduled at times other than school hours.)

Specific directions or information for administration _____

Date of order _____ Discontinuation date _____

Diagnosis _____

Consent for self-administration/carry (provided the school nurse determines it is safe and appropriate).

Yes _____ No _____

Signature of Licensed Prescriber _____

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PARENTAL CONSENT

I give my permission to have the school nurse or school personnel designated by the school nurse give the

following medicine _____ prescribed by _____
(name of medication and dose) (Licensed Prescriber)

to _____
(name of student)

I give permission for my child to self-administer medication/carry if the school nurse determines it is safe and appropriate. Yes _____ No _____

I give permission to the school nurse to share with the appropriate school personnel information relative to the prescribed medication administration, e.g. adverse side effects, as the nurse determines necessary for my child's health and safety. Yes _____ No _____ Any restriction on release _____

Signature of parent _____ Date _____

(Please note: I understand that the medicine will be destroyed if it is not picked up on the last day of school.)