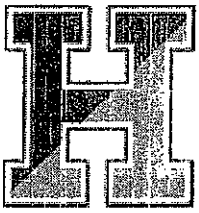

Haverhill Public School Health Department

School Health Services

Medication Order Form

(to be completed by a Licensed Prescriber, Physician, Nurse Practioner or others authorized by Chapter 94C)

Name of Student_____ Date of Birth _____ ___

Address_____ Grade _____

Name of Licensed Prescriber_____Title _____

Business Phone_____ Emergency Phone _____

Medication_____

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*_____

Any other medical condition(s)* _____

Optional Information

1. Special side effects, contraindications, or possible adverse reactions to be observed

_____

2. Other medication being taken by the student:_____

_____

3. The date of the next scheduled visit or when advised to return to prescriber: _____

4. Consent for self administration (provided the school nurse determines it is safe and appropriate). Yes_____ No _____

_____

Signature of Licensed Prescriber

* if not in violation of confidentiality.

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Haverhill Public School Health Department
School Health Services
Written parent/guardian consent for medication administration

Student's name: _____

Date of Birth: _____ Sex: _____Grade: _____

Parent/Guardian printed name: _____

Address: _____

Telephone number—Home: _____ Cell Phone number: _____

Telephone number—Work: _____ Emergency: _____

Other person(s) to be notified in case of medication emergency:

Name: _____ Telephone number: _____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality): (Please list all medications the child is receiving)

1. _____ 2._____ 3. _____ 4._____

My son/daughter has the following food or drug allergies: _____

I consent to have the school nurse or school personnel designated by the School Nurse administer the medication _____ prescribed by:

(name of medication)

_____ to _____

(Licensed Prescriber) (Student's Name)

I give permission for my son/daughter to self-administer medication, if the school nurse determines it is safe and appropriate. _____Yes _____No

I give permission to the School Nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Parent/guardian signature_____

Relationship to Student_____ Date: _____

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