# MEDICATION ADMINISTRATION PLAN
# &
# PARENT/GUARDIAN CONSENT

**1102 Hancock St. Quincy, MA 02169 Phone: 617-773-5610 Fax: 617-770-1551**

Student's Legal Name: _____ Preferred Name: _____ Date of Birth_____ Grade_____

Student's Primary Address: _____

1. Parent/Guardian Printed Name & Relationship: _____ Phone: _____

2. Parent/Guardian Printed Name & Relationship: _____ Phone: _____

Emergency Contact *(other than a parent/guardian who may be contacted in an emergency if the parent/guardian is unavailable)*:

Name: _____ Relationship: _____ Phone: _____

- Please complete the following sections in as much details as possible:

Medical Diagnoses (if not in violation of confidentiality): _____

All medications your child is currently receiving, including those given during the school day (if not in violation of confidentiality):

_____

Food/Drug Allergies: _____

****I give my permission for the school nurse (or trained professional in the case of EpiPen) to administer the following medication(s) to my child as prescribed by their physician (please list):**

_____

****I give permission for the school nurse to share information relevant to this medication as she determines necessary for my child's health and safety.** Yes _____ No _____

- Please complete the following information which will be reviewed with the school nurse:

Name of Prescriber: _____ Date Ordered: _____ Duration of Order: _____

Expiration Date of Medication Provided to School: _____ Possible Side Effects/Adverse Reaction: _____

Plan for Field Trips (*please circle one*):
Not Needed on Field Trip Parent/Guardian Will Chaperone Student Self Administer (PAGE 2 MUST BE COMPLETED)

***** STUDENT SELF ADMINISTRATION OF MEDICATIONS IN SCHOOL:***

***Massachusetts Regulations Governing the Administration of Prescription Medications in Public and Private Schools (105 CMR 210.000) Requires that a MEDICATION ADMINISTRATION PLAN be developed with the school nurse for any student who self-administers medication in school. If your child requires self-administration of prescription medications during school hours, please contact ebersell@thewoodwardschool.org to schedule a time to complete your child's medication self-administration plan.***

Plan for Monitoring Medication: Student to return to nurse/front office assigned delegate if needed

Front Office Delegate: _____ (to be completed by school nurse)

***I understand that the medication must be delivered to the health office by a responsible adult, in a properly labeled pharmacy bottle. The medication must be accompanied by a Medical Provider Order. Unused medication must be picked up within one week of the termination of the physician's order or within two days after school ends or it will be discarded.***

**Consent for administration of medication in school**: I consent to have the school nurse or school personnel designated by the school nurse administer the medication as prescribed by their physician.

Parent/Guardian Signature: _____ Date: _____
School Nurse Signature: _____ Date: _____

# STUDENT SELF ADMINISTRATION OF MEDICATIONS IN SCHOOL

*Massachusetts Regulations Governing the Administration of Prescription Medications in Public and Private Schools (105 CMR 210.000) Requires that a MEDICATION ADMINISTRATION PLAN be developed with the school nurse for any student who self-administers medication in school.*

***PAGE 1 MUST BE ATTACHED TO THIS FORM.***

Student's Legal Name: _____ Preferred Name: _____ Date of Birth_____

****I give my permission for my child to self-administer her epinephrine _____ and/or inhaler _____ and/or OTHER (please list): _____ as prescribed by their physician** Yes _____ No _____

**STUDENT SELF ADMINISTRATION PLAN:**

Location for medication:
- Health Room
- Carried with student (inhalers ONLY)

Location where medication administration will occur:
- Health Room
- Other (specify)_____

Plan for monitoring medication, if needed:_____

If medication is self-administered at school, student will report to health office and notify school nurse, or front office assigned delegate (_____) of time of medication administration. Date, time, and reason administered to be documented by school nurse (or assigned delegate) in 360. Parent/Guardian will be notified by phone/email of medication administration.

OTHER:

Parent/Guardian Signature: _____ Date: _____

Student Signature: _____ Date: _____

*********** For Use By Health Office ***********

I have instructed this student in the proper way to use their medications and reviewed the self-administration plan with both the student and their parent/guardian. It is my professional opinion that this student may self-administer the medication and may be allowed to carry and use their medications by themselves.

COMMENTS/SPECIAL INSTRUCTIONS:

Date medication administration plan completed: _____

School Nurse Signature: _____ Date: _____