Hadley School Department
Medication Order

This form must be completed in its entirety and signed by a <u>licensed prescriber: physician, nurse practitioner</u> or other person authorized by MGL Chapter 94C.

Name of student ____ DOB __________

Address ____ Grade _________
street town zip

Name of licensed prescriber ____ Title ___________

Business Telephone __________________________ Emergency Telephone _______________________

Allergies to: ______________________ food _________________ medicine __________________other

Medication #1
Name __________________________ Dosage ____________ Route _____________ Time __________

Side effects, contraindications, or possible adverse reactions to watch for: _________________________
____

Diagnosis: ____

Discontinuation Date: ____
(order will be considered effective for one year unless otherwise specified)

Medication #2
Name __________________________ Dosage ____________ Route _____________ Time __________

Side effects, contraindications, or possible adverse reactions to watch for: _________________________
____

Diagnosis: ____

Discontinuation Date: ____
(order will be considered effective for one year unless otherwise specified)

1. Is supervised self-administration of medication approved, provided the school nurse determines it is safe and appropriate in the school setting and the parent(s) agree? (The student is monitored by staff while taking the medication, does not have access to other student's medications and the medication is stored in a locked cabinet at all time.) Yes ____ No ____

2. If this student utilizes a rescue inhaler for asthma, and the school nurse determines that it is appropriate and safe, may they carry their own inhaler and self-administer; reporting to the nurse if more than one dose is required? Yes ____ No ____

3. If this student utilizes a rescue inhaler for asthma, and the school nurse determines that it is appropriate and safe, may they carry and self-administer on a school field trip and during school athletics? Yes ____ No ____

4. If this student utilizes an Epi-Pen for an anaphylactic reaction, and the school nurse determines that it is appropriate and safe, may they carry and self-administer on a school field trip and during school athletics? Yes ____ No ____

____
Physician Signature Date

Hadley School Department
Parent Permission for Medication Administration

Name of student ____ DOB __________

Name of Parent/Guardian ____

Address ____
street town zip

Telephone #'s ____________________ ____________________ ____________________
home work cell

Allergies to ____________________ food ____________________ medication ______________other

Medication #1			
Name ______________________	Dosage __________	Route ___________	Time _________
Medication #2			
Name ______________________	Dosage __________	Route ___________	Time _________

1. Is supervised self-administration of medication approved, provided the school nurse determines it is safe and appropriate in the school setting and the physician agrees? (The student is monitored by staff while taking the medication, does not have access to other student's medications and the medication is stored in a locked cabinet at all time.) Yes ____ No ____

2. If this student utilizes a rescue inhaler for asthma, and the school nurse determines that it is appropriate and safe, may they carry their own inhaler and self-administer; reporting to the nurse if more than one dose is required? Yes ____ No ____

3. If this student utilizes a rescue inhaler for asthma, and the school nurse determines that it is appropriate and safe, may they carry and self-administer on a school field trip and during school athletics? Yes ____ No ____

4. If this student utilizes an Epi-Pen for an anaphylactic reaction, and the school nurse determines that it is appropriate and safe, may they carry and self-administer on a school field trip and during school athletics? Yes ____ No ____

5. I give permission for the school nurse or nurse leader to delegate administration of this (these) medication (s) to another staff member who has been trained in medication administration procedure. Yes ____ No ____

6. I give permission for the school nurse to share with appropriate school personnel information relative to the administration of prescribed medication, ie. adverse side effects, as s/he deems necessary for my child's health and safety. Yes ____ No ____

As a parent I agree to respond promptly when notified by the school nurse that my child's medication supply is getting low or if a medication (such as an inhaler or Epi-Pen) has an imminent expiration date.

Please note that medications may be picked up at any time by a parent/guardian during school hours. 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.

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Parent/Guardian Signature Date