Hadley Public Schools Medication Order

This form must be completed in its entirety and signed by a licensed prescriber: physician, nurse practitioner 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/medication/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, 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 ____

_____ _____

Prescriber Signature Date