

MAIMONIDES SCHOOL MEDICATION ORDER

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

Student's Name _____ Date of Birth _____ Sex _____

Home Address _____ Grade _____

Name of Licensed Prescriber _____ Title _____

Business Telephone Number _____ Emergency Number _____

Medication _____

Route of Administration _____ Dosage _____

Frequency _____ Times of administration _____

(Please note: Whenever possible, medication should be scheduled at times other than school hours.)

Specific directions of 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

Date

(over)

**MAIMONIDES SCHOOL
WRITTEN PARENT/GUARDIAN CONSENT
FOR MEDICATION ADMINISTRATION**

Student's Name _____ Date of Birth _____ Sex _____
Name of Parent/Guardian _____ Student's Grade _____

Address _____
Tel. Number (Home) _____ Tel. Number (work) _____
Emergency Contact Number _____

Other people, if any, to be notified in case of emergency of parent/guardian is unavailable:

Name _____ Relationship _____ Tel. Number _____

My child is currently receiving all the following medications (to be completed if not in violation of confidentiality – please list all medicines the child is receiving, including those given during the school day):

1. _____ 2. _____ 3. _____

My child is known to have the following allergies: _____

* * * * *

CONSENT

1. I give permission to have the school nurse or school personnel designated by the school nurse give the following medicine _____ prescribed by _____ to _____
(name of medicine) (licensed prescriber)

_____ on these dates _____ at this time _____.
(name of student)

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

3. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medicine administration, e.g. adverse side effects, as s/he determines necessary for my child's health and safety.
 Yes No Yes, but with the following restrictions _____

(Please note: I understand that I may retrieve the medicine from the school at any time and that the medicine 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.)

SIGNATURE OF PARENT/GUARDIAN RELATIONSHIP TO STUDENT DATE