Westfield Public Schools

Medication Order, Parent Consent, and Medication Administration Plan

Student's Name________________________________ Date of Birth____________ Allergies________________

School___________________________________ Grade_________ Teacher____________________________

Name of Parent/Guardian____

List all medications to student is currently taking____

____

Can student self-administer if determined appropriate by the nurse? ____yes ____no

Self-administration plan____

Half day/early release plan____

Field trip plan/Delegation____

I request the above named child be administered the medication listed below as authorized by myself and the prescribing provider below. I understand that I may retrieve the medication at any time and the medication will be destroyed if not picked up by the end of the day on the last day of school.

______________________________ ________________ __________________ ________________
Signature of parent/guardian Home Phone Work Phone Cell Phone

______________________________ ________________
Relationship to student Date

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The following to be complete by the licensed prescriber as authorized by Chapter 94C:
Whenever possible, medications will be scheduled outside school hours.

Name of medication:____________________________ Dose________________Route________Time________

Diagnosis for medication given:____

Significant Side Effects____

Monitoring required for side effects____

Start Date______________________ Discontinue Date________________________

Other Information____

Printed name of licensed prescriber____ Date______________

Signature of licensed prescriber____

Office phone number_________________________

School nurse signature____ Date______________