

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 _____