GROTON-DUNSTABLE REGIONAL SCHOOL DISTRICT

LICENSED PRESCRIBER MEDICATION ORDER FORM

Student Name: ____ **DOB:** ____________________

SECTION 1 – PRESCRIBER INFORMATION

1. Licensed Prescriber's Name: ____
2. Title: ☐ MD ☐ DO ☐ NP ☐ PA ☐ Other:______________________________
3. Business Phone: ____________________________ Fax: _________________________________

SECTION 2 – MEDICATION INFORMATION

Whenever possible, please try to scheduled medication at times other than school hours.

1. Child's Diagnosis: ____
2. Medication Name: ____
3. Dose: _________________________________ Frequency: ______________________________
3. Route: ☐ PO ☐ Inhaled ☐ IM ☐ SC ☐ Other: _____________________________
4. Additional directions or instructions for administration:____________________________________
   ____
   ____
5. Side effects, contraindications, or possible adverse reactions school staff should be aware of and observe for (please list): ____
   ____
   ____
6. Start Date: ____________________ End Date: ____________________
7. Other medication student is taking: ____
   ____
8. Any other medical concerns: ____
   ____
8. Date of next scheduled visit or when advised to return for follow up: ______________
9. Can student self-administer this medication (if school nurse determines it is safe and appropriate):
   ☐ Yes ☐ No

*****<u>PLEASE NOTE: STUDENTS ARE NOT ALLOWED TO SELF-ADMINISTER CONTROLLED SUBSTANCES (I.E. RITALIN, ETC.)</u>*****

Date: __________ **Prescriber's Signature:** ____

Please return this form to: Phyllis Lang, RN; Florence Roche School , PO Box 738, Groton, MA 01450 Fax: 978-448-3988

GROTON-DUNSTABLE REGIONAL SCHOOL DISTRICT

PARENTAL CONSENT FOR THE ADMINISTRATION OF MEDICATION IN SCHOOL

SECTION 1 - STUDENT INFORMATION		
Student Name: ______________________		**DOB:** __________
Building: ________________	**Grade:** ________	**YOG:** __________
Parent Name: ________________	Home Phone: ________________	
Cell Phone #: ________________	Work Phone: ________________	
List student's allergies: ______________________		
List other medication student is taking: ______________________		

SECTION 2 – MEDICATION INFORMATION			
1. Name of Medicine: ______________________			
2. Dose: ______________	Time(s) to be given: ______________		
3. Route: ☐ Orally	☐ Inhaled	☐ Injected	☐ Other: ______________
4. Start Date: ______________	End Date: ______________		

SECTION 3 – PARENTAL CONSENT	
1. I give permission for my child to self-administer the medicine if the school nurse determines it is safe and appropriate: ☐ Yes ☐ No ***PLEASE NOTE: STUDENTS ARE NOT ALLOWED TO SELF-ADMINISTER CONTROLLED SUBSTANCES (I.E. RITALIN, ETC.)***	
2. I give the nurse permission to share with the appropriate school personnel information relative to the prescribed medicine administration (such as side effects) as she determines necessary for my child's health and safety: ☐ Yes ☐ No Any restrictions? Please list: ______________	
3. Do you want this medicine given on half days? ☐ Yes ☐ No	
4. When appropriate, can this medicine be given to your child by designated school personnel, while participating on a field trip? ☐ Yes ☐ No	
5. I give permission to the nurse or her designee to give the above named child this medication: ☐ Yes ☐No	
Date: ________	**Parent/guardian Signature:** ______________________
Printed Name: ______________________ **Relationship:** ____________	
Remember to pick up the medication upon completion. All medicines remaining in the nurse's office will be discarded on the last day of school.	
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