Arlington School – 115 Mill Street, MS 111, Belmont, MA 02478 – (617) 855-2124

Prescription Medication Administration Plan and Consent Form

Student Name _____ **DOB** _____

Primary Address _____

_____ Zip _____

Parental Contact _____ **Emer Contact** _____

Home _____ Home _____

Cell _____ Cell _____

Work _____ Work _____

In conjunction with the ***Prescription Medication Order Form, #M4.01***, please list, within your statement of consent, the prescription medication and its' dosage your child will receive during the school day.

CONSENT

I give permission to the school nurse, or an authorized school staff member, to give the following ***prescription medicine***, _____ ***dose*** _____ which has been ***prescribed by***, _____ to ***my child***, _____ . ☐ YES ☐ NO

I give permission for my child to self administer the above mentioned medication if the school nurse determines it is safe and appropriate: ☐ YES ☐ NO

I give permission to the school nurse to share with appropriate school personnel information relating to the administration of the above mentioned prescription medications in relation to my child's health and safety. ☐ YES ☐ NO

I give permission to the school nurse, or an authorized school staff member, to give the above mentioned medication while on school authorized field trips: ☐ YES ☐ NO

I understand that I may retrieve the above mentioned prescription 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 **Date**

Medication Administration Plan

For Office Use Only

Student Name _____ DOB _____
Height _____ Weight _____ Gender _____ Grade _____

Licensed Prescriber: _____
Business Number: _____ Fax Number: _____

Name of Medication _____

Qty of Medication Received: _____ Date: _____

Date Ordered: _____ Expiration Date: _____

Duration of Order: _____ Dosage: _____ Frequency: _____

Route of Administration: _____

Specific Directions: *(times to be given)*

AM: _____ PM: _____ As Needed: ☐

Required Storage Conditions: _____

Possible Side Effects: _____

_____

Administration Location: _____

Plan for Monitoring: _____

_____

Delegated to: _____

Back-up Plans *(if delegate is unavailable)* : _____

Plan for Field Trips: _____

Plans for teaching self administration, if applicable: _____

_____

Other persons to be notified of medication administration: _____

Other medications being taken by the student : _____

School Nurse Signature_____ **Date:**_____