Dear Parent/Guardian, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_

Your child/ward has the following medications at school\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ according to our records. We currently have\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of the medication. We will need you to complete page 2 of this “packet”. The doctor can complete the top part **or** *he/she may fax an order to the fax number below* (also on top of pg 2). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Below you will see our procedure as well as the form that will need to be completed (at the beginning) every school year as mentioned below. *If your child no longer takes this medication at school please let me know when you will be picking it up.* Medications have to be delivered to the nurse by the parent or guardian. Medications cannot be sent in with the student. All meds needs to be dropped off to and picked up from the nurse. I apologize for any inconvenience that this may cause. We will look forward to seeing you soon.

Sincerely,

Michele Reidt RN

**Licensed Prescriber Order and Parent/Guardian Consent Form**

The Medication Procedure for the Keefe Regional Technical High School (KT) requires that the attached Licensed Prescriber Order and Parent/Guardian Consent form **(see page 2 of this document)** be completed and delivered to my office, along with all necessary medication per MA regulations 105 CMR 210.000. Please note that this form has two different parts that need to be filled out:

**1. Signed order by the child’s licensed prescriber** (physician, nurse practitioner or other provider authorized by Chapter 94C). This order must be renewed at the beginning of each school year and revised during the academic year if there is a change in the medication your child receives at school. Parents, please do not write anything in the Licensed Prescriber section; the doctor will complete this portion of the form.

**2. Signed consent by the parent/guardian to give medication**

*I must have the completed form on file in your child’s health record in order to administer medication to him/her at school.* Before you bring your child's medication to school, please make sure it is in the labeled original pharmacy container/bottle or box in the case of Epi Pens or inhalers, and check all expiration dates.

**KT Medication Procedures**

In particular, note that **only EpiPens** will be sent with your child or his/her chaperone on any school field trip with no nurse in attendance.

If you have any health related nutrition or dietary concerns, please contact Susan Brown, food service director, [sbrown@jpkeefehs.org](mailto:sbrown@jpkeefehs.org). I have given her a list of allergies that I am aware of but please be sure to reach to me myself (Michele, School Nurse) to be sure we have the most up to date list for your child/ward. Thanks again.

**Contact Information for the Nurse**

|  |  |
| --- | --- |
|  |  |
| Michele Reidt BSN, RN, NCSN |  |
| Phone: 508-416-2263 |  |
| Fax: 508-416-2120  [mreidt@jpkeefehs.org](mailto:mreidt@jpkeefehs.org) |  |

750 Winter Street

Framingham, MA 01702

** KEEFE REGIONAL TECHNICAL HIGH SCHOOL**

CAN BE FAXED TO:

508-416-2120 (in RN office)

Questions? 508-416-2263

**Michele Reidt BSN, RN, NCSN**

**LICENSED PRESCRIBER ORDER**

(To be completed by Physician, Nurse Practitioner,

Or other authorized by Chapter 94C)

**Student Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Grade**\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please print student’s name)

**Licensed Prescriber** (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(MD name and address)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Telephone** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FAX**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(address cont)

**Diagnosis**\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication** **Dose** **Route** **Frequency** **Time**\_\_\_\_\_\_\_\_\_\_\_\_\_

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Possible side effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student may self-administer if School Nurse determines it is safe and appropriate: YES\_\_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_\_\_

**NOTE: *Whenever possible, medication should be given at home to avoid school hours***

**Prescriber’s** Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_ Stamp if applicable\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(MD/NP/DO etc.)

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION**

I give permission for the School Nurse to administer the medicine(s) *listed below* to my child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

as prescribed by Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other medications my child currently takes:

Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drug\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission for teacher or designated adult to administer during field trips………….…… YES\_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_

Permission to share pertinent medication information with appropriate school personnel: YES\_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_

Permission to self-administer if the School Nurse determines it is safe and appropriate: YES\_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_

***I will supply & deliver to the nurse the medication in the labeled original pharmacy container. I understand that the nurse may only store a 30 day supply of medication. The medication will be destroyed if it is not picked up by the last day of school.***

Parent / Guardian (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent / Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phones: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_