Burlington Public Schools

Medication Administration Plan and Consent

Student: ___________________ Date of Birth: _______ Weight: _____ Grade: ______ Homeroom: ______

Medical Diagnosis: ____

Child's Known Allergies: ____

Order Section

The **health care provider** must complete this section.

Please Note: *Medications should only be administered during the school day when necessary. Due to State Laws* ***all "Over The Counter Medications" require a prescriber's order:*** *this includes Motrin, Diastat, Glucagon, Imitrex, Tums, and/or cold medications.*
A nurse can only delegate "tasks" to medically -unlicensed school personnel and cannot delegate assessment skills with the administration of "as needed" medications.

Medication	Dose	Route	School Administration Time(s)/Frequency	Additional Directions	Side Effects

This Medication can held or given late on Field trip days: Yes __________ No _____________

Reason for medication: _____________________________ Date Ordered: _________ Discontinue Date: _____

Licensed Prescriber: ____________________ ________________________________ ______
(**Print name**) (**Prescriber's Signature and Title**) Date

Must be manual: may not be rubber-stamped, according to the Commonwealth of Massachusetts Board of Registration in Medicine Prescribing Practices and Policy Guidelines adopted Aug. 1, 1989 and amended Dec. 12, 2001.

Prescriber's Phone Number: __________________________/__________________________________
(Office #) (Prescriber's emergency #)

Date advised to return to prescriber: _____________ Required storage of medication: _________________

Parent/Guardian ____________________________/_______________/__________________/_________________
(Print Name) (Home #) (Cell #) (Work #)

Parent/Guardian ____________________________/_______________/__________________/_________________
(Print Name) (Home #) (Cell #) (Work #)

Emergency Contact__________________________/________________/___________________/__________________
(Relationship to child) (Home #) (Cell #) (Work #)

Please see additional consents on the back of this form

Medication Administration Plan and Consent. . . continued

Student: ____________________ Date of Birth: _______ Weight: _____ Grade: ______ Homeroom: ______

In the event of a Field Trip: (please initial all that apply)

____ May omit medication for field trips.
____ I or my designee will attend my child's field trips and assume responsibility of my child's medical & medication needs.
_____ My child may self-administer, if the child can demonstrate competency. (***Nurse must assess and evaluate "Yes" below**).
____ *I give permission for a responsible adult trained by the school nurse to give my child their medication. ***Please note**: *Due to State Laws the nurse can only delegate tasks to medically unlicensed school personnel and cannot delegate assessment skills. Thus "as needed medications" cannot and will not be delegated (i.e., but not limited to Motrin, Diastat, Glucagon, Imitrex, Tums, and/or cold medications).*

Medication Plan for early release: ______________________________ **Plan for delayed openings**: ____________________________

_____Yes _____No I give the school nurse permission to share information, relative to prescribed medication with appropriate personnel as necessary for my child's safety and health (i.e., adverse side effects).

_____Yes _____No I give the school nurse permission to speak to my child's prescriber listed on this sheet to ensure the wellness and safety of my child.

_____Yes _____No I give the school nurse permission to photograph my child for identification purposes related to medication administration.

I give permission for the school nurse to give (student's name) ____ his/her (medication) ____ which I will supply in its original and/or pharmacy- labeled container.

Parent/Guardian's Signature: ________________________________ Date: ___________________

Please list all the medications the child currently takes *(if this changes any time during the school year, please contact the school nurse)*: ____

Please note: *All medications must be in their original and/or pharmacy-labeled containers and delivered to the nurse by a responsible adult. They may be retrieved by the parent/guardian at any time. Medications will be disposed of if they are not picked up within one week following the order's termination or at the completion of the last day of school.*

For Health Office Use Only

Student has demonstrated competency in medication self administration:

___Yes ___No ______Date Nurse's name printed: ______________________ Nurse's' signature: _______________________
___Yes ___No ______Date Nurse's name printed: ______________________ Nurse's' signature: _______________________
___Yes ___No ______Date Nurse's name printed: ______________________ Nurse's' signature: _______________________

Medication storage location: ________________________________ Date Medication EXPIRES: ____________

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