NORTH ANDOVER PUBLIC SCHOOLS

Consent for Medication Administration

Name of Student______________________________DOB___________School__________________________

Address____Telephone______________________

Parent/Guardian Name____Daytime Phone__________________

Name of Licensed Prescriber___________________________________Phone__________________________

Medication is to be supplied in the prescription bottle/box. Please ask your pharmacist for a duplicate bottle so that you may have one for home and one for school.

PHYSICIAN'S ORDER

I, the undersigned licensed provider, request that the school nurse or other designated person administer the medication I have prescribed below.

Diagnosis_______________________**Food/Drug Allergies**_____________________________________

Medication__________________________________**Start Date**____________**End Date**_____________

Dosage_________________**Route**______________**Frequency**_____________**Time**_________________

Possible side effects____

Physician Signature____**Date**_____________________

Comments____

PARENTAL/GUARDIAN CONSENT

I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medication administration, e.g. adverse side effects, as determined necessary for my child's health and safety.

I give my permission for the school nurse or designated school personnel to administer the above medication to my child during school hours.

Date_________________**Parent/Guardian Signature**____

Medication can be retrieved from the school by the parent at any time and will be discarded if it is not picked up within one week following termination of the order, upon expiration or on the last day of school.