Mashpee Public Schools
Medication Administration Plan & Field Consent

To Completed by Parent or Guardian

Student Name: _____ Male Female
Birthdate: _____ Grade:_____

Parent/Guardian Name:_____Home Phone #:_____
Emergency Phone #:_____ Work Phone #:_____

Diagnosis:_____Known Allergies:_____

1. I request and give permission to the assigned teacher/chaperone to give my son/daughter:
   Medication:_____ Dosage:_____
   Route:_____ Time of Day:_____
   Prescriber:_____ Date of Order_____to_____
   Possible side effects:_____
   _____

2. Refrigeration ____Yes _____No
Other medications student currently taking:_____

3. I give permission for my son/daughter to self-administer their inhaler/over-the-counter medication if determined it to be safe and appropriate. ____Yes ____No

4. I give permission for my child's teacher/chaperone to administer the above medication on a field trip. ____Yes ____No

5. I understand that in the event of a field trip, this medication administration plan may need to be altered. It is my responsibility to call the school nurse prior to a field trip to discuss the plan for administering this medication.

This medication maybe held (not given) on the day of the field trip. ____Yes ____No

6. I give the school nurse permission to share with appropriate school personnel information related to the prescribed medication as he/she determines necessary for the health and safety of my child. ____Yes ____No

7. I understand that I may retrieve the medication from school at any time, and that the medication will be destroyed if it is not picked up by the last official day of school.

8. I give permission for my child's picture to be placed on the medication log sheet for the purpose of proper identification. ____Yes ____No

All medications will be held by the teacher/chaperon on a field trip.

Parent/Guardian Signature:_____Date:_____

School Nurse Signature:_____Date:_____

To be completed by a Licensed Prescriber, Physician, Nurse Practioner
Or others authorized by Chapter 94C

Name of Student:_____Date of Birth:_____
Address_____Grade:_____
(street) (city/town)

Name of Licensed Prescriber_____Title_____
Business Telephone #_____Emergency Telephone #_____

Medication_____

Route of administration_____Dosage_____
Frequency_____Time(s) of administration_____
(*Please note: Whenever possible, medication should be scheduled at times other than school hours)*

Specific directions or information for administration_____

Date of Order_____Discontinuation Date_____
Diagnosis or medical condition*_____

Any other medical condition(s)*_____

Optional Information

1. Special side effects, contraindications, or possible adverse reactions to be observed:_____
2. Other medications being taken by the student:_____
3. The date of the next scheduled visit or when advised to return to prescriber:_____
4. Consent for self administration (provided the school nurse determines it is safe and appropriate) . _____Yes_____No

_____
___
Signature of Licensed Prescriber

*if not in violation of confidentiality