HOLLISTON PUBLIC SCHOOLS

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Medication Administration Plan

Name of Student: _____ DOB: _____	Parent/Guardian Name: _____
School: _____ Grade: _____	Cell Phone: _____
Name of Lic. Prescriber: _____	Parent/Guardian Name: _____
Phone Number: _____	Cell Phone: _____
Fax Number: _____	Emergency Contact (other): _____

Food Allergies: _____

Diagnosis (if not in violation of confidentiality): _____

Name of Medication: _____ Date Ordered: _____ Duration of Order: _____

Dosage: _____ Frequency: _____ Route of Administration: _____

Specific Directions (eg., times to be given): _____

Possible Side Effects/Adverse Reactions and when to call school nurse: _____

Delegated to (if applicable): _____ Back-Up Plans (if delegate unavailable): _____

Plan for Field Trip:

☐ Sent on Field Trip and administered by designated school personnel.

☐ Other _____

Other persons to be notified of medication administration (with parental permission):

☐ Appropriate School Personnel relative to prescribed medication necessary for student health and safety.

☐ Other _____

Required storage conditions: _____ Storage Location of medication: ☐ Health Office ☐ Other: _____

Plan for monitoring medication, if needed: _____

Plan for teaching self-administration (as appropriate) applicable only for prescription inhalers, epinephrine auto-injectors, insulin delivery systems, and enzyme supplements: ☐No ☐Yes (MUST complete second page)

Parent/Guardian Signature: _____ Date: _____

Reviewed and approved by Nurse (signature): _____ Date: _____

Medication order and parent/guardian authorization may be attached to this form.

* ONLY COMPLETE THIS SECTION FOR SELF-CARRY / ADMINISTRATION *

Self-Carry / Administration will be allowed only when the criteria of the Self Administration Medication Plan have been met. The plan is effective only for the same school year it is granted and must be renewed each year.

Parent / Guardian Consent of Administration

I, the parent/guardian of _____, give permission for my child to self-administer the above listed medication.

Parent / Guardian Name (printed): _____

Parent / Guardian Signature: _____ Date: _____

Student Consent of Administration

Responsibilities:

1. Student demonstrates knowledge of the medication and when it should be used ☐ Yes ☐ No
2. Student informs the nurse if there are any issues with self-administration. ☐ Yes ☐ No

Student Name (printed): _____

Student Signature: _____ Date: _____

School Nurse Consent to Student Medication Self Administration Plan

Self-administration of medication in the school setting will be allowed if the following are met:

- A valid medication order and treatment plan from a licensed prescriber has been received.
- The student's parent/guardian has completed and submitted to the school any written documentation required by the school.
- The school nurse has developed a Medication Administration Plan (MAP) which contains only those elements necessary to ensure safe self-administration of medication.
- The minor student's parent/guardian has signed the Consent of Administration.
- The student has demonstrated to the school nurse the skill level necessary to use the medication and any device necessary to administer such medication prescribed and has reviewed and signed the Consent of Administration.
- The school nurse has determined it is safe and appropriate for the student to self-administer the prescribed medication and has signed the Consent for Self-Administration.
- The signed consent for self-administration in the school setting will be kept with the student's medication orders in their medical file.

School Nurse Name (printed): _____

School Nurse Signature: _____ Date: _____