**Pembroke Public Schools**
Pilgrim Road, Pembroke, MA 02359
Ph: 781-829-0832
www.pembrokek12.org

# MEDICATION ADMINISTRATION PLAN

Name of Student: _____ DOB _____ Parent/Guardian Name: _____
School: _____ Grade: _____ Home Telephone: _____
Business Telephone: _____
_____ Emergency Telephone: _____
Name of Licensed Prescriber: _____
Business Telephone: _____
Emergency Telephone: _____

Food/Drug Allergies: _____
Diagnoses: _____
Name of Medication: _____ Date of Order: _____
Dosage: _____ Frequency: _____ Route of Administration: _____ Expiration Date: _____
Specific Directions (e.g., times to be given):
_____
Possible Side Effects/Adverse Reactions and when to call the school nurse:
_____
Required Storage Conditions: _____
Plan for Field Trips: _____
Permission for Self-Administration: YES _____ NO _____
Permission to self-carry medication: YES _____ NO _____
Other Medications being taken by the student (if not in violation of confidentiality):
_____
Location where medication administration will occur: Health Room _____ Other (specify)_____

I give permission to the School Nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

School Nurse Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Student's Signature *(if appropriate)*: _____ Date: _____

Physician Signature: _____ Date: _____