DUDLEY-CHARLTON REGIONAL SCHOOL DISTRICT

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68 Dudley-Oxford Road
Dudley, Massachusetts 01571
Gregg J. Desto
Superintendent of Schools

William J. Trifone
Finance Director
Jody A. O'Brien
Administrator of Special Needs
Lorinda C. Allen
Director of Curriculum and Student Assessment

Dear Parent/Guardian:

The following information is provided to make you aware of the Dudley-Charlton Regional School District practices in place to ensure the health and safety of children needing medication during the school day.

You, or a responsible adult designee, should deliver the medicine to school. Please ask your pharmacy to provide separate bottles for school and home. No more than a 30-day supply of the medicine should be delivered to the school.

The Dudley-Charlton Regional School District requires that the following forms be on file in your child's health record before medicine can be given at school:

- A consent form signed by the parent or guardian authorizing the administration of medicine should be completed when the medication is brought into school.
- A signed medication order. The written medication order form should be taken to your child's licensed prescriber (your child's physician, nurse practitioner, etc.) for completion and returned to the school nurse. This order must be renewed as needed *and* at the beginning of each academic year.
- Emergency Procedure Card. This card must be on file with the school nurse at the beginning of each school year.

When your child needs medication to be given during the school day, we ask you to please act promptly to follow these practices. If you have any questions, please contact your school nurse.

Sincerely,

Gregg J. Desto

Gregg J. Desto
Superintendent of Schools

DUDLEY-CHARLTON REGIONAL SCHOOL DISTRICT

Medication Order

(to be completed by Physician, Nurse Practitioner, or others as authorized by Chapter 94C

Name of Student_____ DOB_____
Please print

Address_____
(street) *(city/town)* *(zip)*

Emergency Telephone_____ Work Telephone_____

Name of Licensed Prescriber:_____

Diagnosis*_____
if not in violation of confidentiality

Medication_____ Dosage_____

Frequency/Time_____
(whenever possible, medication should be scheduled at times other than school hours)

Date of Order_____ Discontinuation Date_____

*Any other medical condition(s)*_____

Optional Information

*1. Special side effects, contraindications, or possible adverse reactions:*_____

*2. Other medication taken by 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