

# Webster Public Schools

## Medication Order for Provider

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

\*\*\*Please print clearly in all fields.\*\*\*

Name of Student:	DOB:
Food/Medication Allergies:	

Provider Name:	NPI #:
Provider Telephone #:	
Medication to be administered:	
Dosage:	Frequency:
Date of order:	Discontinuation date:
Condition for which medication is being administered:	

Optional Information:
Special side effects, contraindications or possible adverse reactions:
Other medication taken by student:
Date of next scheduled visit or when advised to return to prescriber:
Consent for self administration (provided the school nurse deems it safe and appropriate): <input type="checkbox"/> Yes <input type="checkbox"/> No

<i>I certify that the above student is under my care and that it is <b>necessary</b> to administer the above medication to them during school hours. I have provided the student and the parent/guardian with all appropriate information concerning the use and possible side effects of this medication. I further certify that this medication does not contain any of the restricted psychotropic drugs as defined in Chapter 71, Sec 54B.</i>	
Provider Signature:	Date:

*This authorization automatically expires at the medication ending date unless revoked sooner. Webster Public Schools reserves the right to reject any requests which they cannot effectively handle or which present undue risks.*

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## Parent/Guardian Consent for Medication Administration

General Information	
Student Name:	Date of Birth:
School:	Grade:
Parent/Guardian Name:	
Address:	
Primary Phone #:	Alternate Phone #:
Please note any allergies to food/medication:	
Please note any other medication the child is currently taking:	

Consent
Name of medication:
Prescribing Physician:
Prescribing Physician's Phone #:
<i>I give my consent for the medication named above to be administered to the student named above in accordance with the foregoing instructions. I have been fully informed concerning the use and effects of the medication, and I hereby release, indemnify and hold harmless the Webster Public School System, employees and agents concerning any and all liability which may arise in connection with the administration of this medication.</i>
<i>I give permission to the school Nurse to share information relevant to the prescribed medication administration as they deem appropriate for this student's health and safety.</i>
<i>I understand that 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 beyond the close of school.</i>
Administer lunch dose on half day of school (Dismissal times BHS 10:55a, WMS 11:05a, PAE 12:05p) <input type="checkbox"/> Yes <input type="checkbox"/> No

Parent/Guardian Signature:	
Relationship to student:	Date:

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