

**Hamilton-Wenham Regional School District
Student Services**

Medication Administration Plan

*This form is to be completed by a **parent/legal guardian** before any medication can be dispensed in school per Massachusetts Department of Public Health Regulations 105 CMR 210.000.*

Student name _____ **DOB** _____

School _____ **Grade** _____

PARENT/LEGAL GUARDIAN:

Name of parent/guardian _____

Relationship to student _____

Name of medication(s) to be administered at school _____

Diagnosis _____ Known allergies _____

Please list any additional medications taken at home _____

I, the undersigned parent/guardian, give permission for the school nurse to administer the above prescribed medication to my child. I authorize the school nurse to share information with appropriate school personnel relevant to the prescribed medication administration as she/he determines appropriate for my student's health and safety.

I consent for the school nurse to exchange information with my child's health care provider in order to meet the health care needs of my child.

Signature of parent/guardian _____ Date _____

Phone: home _____ work _____ cell _____

Consent for self-administration (epinephrine auto-injectors, insulin, enzymes, and inhalers only) Has the student been instructed to self-administer the prescribed medication and may the student do so during school and on a field trip (The School Nurse must determine if safe and appropriate to self-administer)

Yes ____ No ____

Medication Storage _____ In locked medication cabinet in health office

Other as noted _____

Any storage instructions _____

We are able to receive and store no more than a 30 day supply of medication.

**Hamilton-Wenham Regional School District
Student Services**

Medication Administration Plan

This form is to be completed by a **licensed prescriber** before any medication can be dispensed in school per Massachusetts Department of Public Health Regulations 105 CMR 210.000. **A prescriber may attach their own complete, signed and dated, medication order form if preferred.**

Student name _____ **DOB** _____

School _____ **Grade** _____

LICENSED PRESCRIBER: Please complete the form if the student is to take medication during school

hours. Date of order _____ Discontinuation date _____

Medication _____ Dose _____

Route _____ Frequency _____ Time(s) to be given at school _____

Possible side effects _____

Special instructions _____

Diagnosis _____ Known Allergies _____

Name of licensed prescriber(print) _____ Title _____

Signature of licensed prescriber _____ Date _____

Address _____ Phone _____

Student may self-administer medication with parent permission if school nurse deems it safe and appropriate

Yes _____ No _____

Additional medication(s)

Medication _____ Dose _____

Route _____ Frequency _____ Time(s) to be given at school _____

Possible side effects _____

Medication _____ Dose _____

Route _____ Frequency _____ Time(s) to be given at school _____

Possible side effects _____