Nantucket Public Schools
10 Surfside Road
Nantucket, MA 02554
508-228-7285 (P)
508-325-5318 (F)

Medication Order Form

To be completed and signed by a Licensed Prescriber

Student Name: _____ DOB: _____
Address: _____ Grade: _____

Name of Prescriber: _____ Title: _____
Phone Number: _____ Address: _____

Medication: _____ Dosage: _____
Route of Medication: _____ Frequency: _____
Time of Administration: _____
(Please note: Whenever possible, medication be scheduled at times other than school hours.)
Specific Directions or information for administration: _____
_____
Date of Order: _____ End Date: _____
Diagnosis: _____
Any Other Medical Condition(s): _____
_____
_____

Other Information:

1. Side effects: contraindications, or possible adverse reactions to be observed:
   _____
   _____
   _____
2. Other medication being taken by the 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: _____ Date: _____

Printed Name of Licensed Prescriber: _____

Parent/Guardian signed *The Consent for Administration of Medication/Medication Administration Plan.*
Licensed Prescriber signes the *Medication Order Form*.
Return both forms to the School Nurse.

Health Offices

NES 508-228-7290 x2107 NIS 508-228-7285 x4107 CPS 508-228-7283 x1405 NHS 508-228-7290 x1404

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Parent/Guardian Consent for Administration of Medication and Medication Administration Plan

Student Name: _____ DOB: _____
Address: _____ Grade: _____
Parent/Guardian #1 Name: _____ #2: _____
Home Phone #1: _____ #2: _____
Cell Phone #1: _____ #2: _____
Work Phone #1: _____ #2: _____
Other Person to be notified in an emergency if the parent/guardian is unavailable:
Name: _____ Phone: _____ Relationship: _____

Name of Licensed Prescriber: _____ Phone: _____

Please list all medications your child is currently receiving (if not in violation of confidentiality):
_____
_____

Diagnosis (if not in violation of confidentiality) _____
Food/Drug Allergies and past reactions: _____

I give permission for the school nurse/school personnel designated by the school nurse to administer the following medication:
Medication name: _____ Dosage: _____
Route: _____ Time to be Given:_____

I give permission for my son/daughter/student to self-administer the medication, if the school nurse determines it is safe and appropriate:
YES _____ NO _____
I give permission for the school nurse to share information relevant to this medication as s/he determines necessary for my son's/daughters/student's health and safety.

I understand the medication must be delivered to the school health office by a responsible adult, in a properly labeled pharmacy container. Also, the medication must be accompanied by a medical provider medication order. I understand that I may retrieve the medication from the school nurse at any time; however, the medication will be destroyed if it is not picked up within one week following the termination of the order or one day beyond the close of the school year.

- *The following is to be completed with the school nurse:* -
Dates/Duration of order: _____ to _____. Date medication received at school health office: _____
Quantity of medication received: _____ *Please note MA state law: We cannot accept more than a 30 day supply at a time.
Expiration date of medication received: _____. Possible side effects/adverse reaction_____
Location/storage of medication: _____
Plan for field trips: _____
Delegated to: _____
Plan for monitoring medication: _____
Plan for teaching self administration with prescriber and parental consent: _____
_____ Date of self medication observation_____

Parent/Guardian signature: _____ Printed Name: _____Date: _____

School Nurse signatureL _____ Printed Name: _____ Date: _____

Student signature (if applicable): _____ Printed Name: _____ Date: _____

Parent/Guardian signs this form. Licensed prescriber signs the *Medication Order Form.* Return both forms to the School Nurse.

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