



GATEWAY REGIONAL SCHOOL DISTRICT

Blandford Chester Huntington Middlefield Montgomery Russell
12 Littleville Road, Huntington, MA 01050

Gateway Regional School District Health Services Department Parental Consent & Medication Administration Plan

Name of student _____ Date of birth _____ School _____ Grade _____

Parent/Guardian 1 Name _____ Phone number _____

Parent/Guardian 2 Name _____ Phone number _____

Other Emergency Contact Name _____ Phone number _____

Food/drug allergies _____

Diagnosis _____

Medication Information

Name of Medication _____ Name of Prescriber _____

Date Ordered _____ Duration of Order _____ Dosage _____ Frequency _____

Route of Administration _____ Expiration Date of Medication Received _____

Specific Directions, times to be given _____

Possible Side Effects, Adverse Reactions _____

Quantity of medication received by school _____ Date _____ Received By _____

Plan for field trips _____

Plans for teaching self-administration, if applicable _____

Other medications taken by student _____

Location where medication administration will occur _____

Plan for monitoring medication _____

I consent to have the school nurse or school personnel designated by the school nurse after trained in medication delegation for field trips administer medication to my child. I give permission to the school nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my child'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 the termination of an order, or if not picked up by the end of the last school day for the school year.

Parent/Guardian Signature _____ Date _____

School Nurse Signature _____ Date _____



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Medication Order Form

The following to be completed by the physician or other licensed provider authorized by Chapter 94C

Student name _____ Preferred Name _____

Date of birth _____ Diagnosis for the medication to be given _____

Name of medication _____ Route _____

Dosage _____ Frequency _____ Time to be given _____

Specific directions or information for administration _____

Can student medicate self if determined to be appropriate by nurse? Yes _____ No _____

IF scheduled morning dose is missed at home, can give dose on arrival to school after verified with in-home adult a dose was missed. Yes _____ No _____

List significant side effects _____

Date to start _____ Date to end _____

Print name of Licensed Provider _____

Signature of Licensed Provider _____

Date _____