



Pembroke Public Schools

Pilgrim Road, Pembroke, MA

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www.pembrokek12.org

MEDICATION ADMINISTRATION PLAN

Name of Student: _____	DOB: _____	Parent/Guardian Name: _____
School: _____	Grade: _____	Home Telephone: _____
		Business Telephone: _____
		Emergency Telephone: _____
Name of Licensed Prescriber: _____		
Business Telephone: _____		
Emergency Telephone: _____		

Food/Drug Allergies: _____

Diagnoses: _____

Name of Medication: _____ Date of Order: _____

Dosage: _____ Frequency: _____ Route of Administration: _____ Expiration Date: _____

Specific Directions (e.g., times to be given): _____

Possible Side Effects/Adverse Reactions and when to call the school nurse: _____

Required Storage Conditions: _____

Plan for Field Trips: _____

Permission for Self-Administration: YES _____ NO _____

Permission to self-carry medication: YES _____ NO _____

Other Medications being taken by the student (if not in violation of confidentiality): _____

Location where medication administration will occur: Health Room _____ Other (specify) _____

I give permission to the School Nurse to share information relevant to the prescribed medication administration as he/she determines appropriate for my son's/daughter's health and safety.

I give permission to the school nurse to delegate administration of this medication(s), (as per Massachusetts medication regulations), to trained personnel while on school sponsored field trips or as needed: Yes _____ No _____

- Medication(s) will be delegated to: _____ Role: _____

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 termination of the order or one week beyond the close of school.

School Nurse Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Student's Signature (if appropriate): _____ Date: _____

Physician Signature: _____ Date: _____