



# Plainville Public Schools

## Medication Order, Parent Consent, & Medication Administration Plan

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_ HR \_\_\_\_ Year \_\_\_\_

### Physician Order: To Be Completed by the Physician (Order may also be attached to this form)

Known Food/Drug Allergies: \_\_\_\_\_

Diagnosis Related to this Prescription: \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Date Ordered: \_\_\_\_\_ Duration of Order: \_\_\_\_\_

Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_ Route: \_\_\_\_\_ Dose Time: \_\_\_\_\_

Special Storage Instructions: \_\_\_\_\_

Specific Directions for Administration: \_\_\_\_\_

Side Effects/ monitoring requirements if needed: \_\_\_\_\_

Other Medications being taken by student: \_\_\_\_\_ (If not in violation of confidentiality)

Physician Name: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Parent Consent: To Be Completed by the Parent/Guardian

#### Parent/Guardian Permissions:

I give the school nurse permission to administer this medication to my child. I understand the school nurse may consult my child's physician about administering this medication to my child. I understand that it is my responsibility pick up this medication when it is no longer needed at school.

★ Please note that noontime/lunch medications will not be given on early release days without a written note from parent/guardian

**Field Trip Plan:** When there is a field trip, this medication will be : Given by Nurse **AND/OR**

Given by designated unlicensed trained school personnel on field trips **AND/OR**

Self-Administered by student, with nurse approval per state mandate (only medications administered in school)

★ Self Administration Medication Authorization Form must be completed and attached if applicable.

#### Food Allergies:

Check here if you would like your child to sit at an allergy-aware table in the cafeteria during meals. Any changes during the school year must be submitted in writing.

Parent/Guardian Printed name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Emergency contact (if parent is not available): \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Medication Administration Plan: To Be Completed by the School Nurse

Location where medication administration will occur: \_\_\_\_\_

Initial quantity of Medication Received by School: \_\_\_\_\_ Date Received: \_\_\_\_\_

*Medication to be recorded in SNAP, the school health documentation system*

Self Administration Authorization Form Completed: \_\_\_\_\_

Delegated to ( if applicable ): \_\_\_\_\_ Back-Up Delegate: \_\_\_\_\_

Approved: YES NO	Nurse Signature:	Date:
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