

Acushnet Public Schools
Acushnet, MA 02743

Elementary School
Health Office
508-998-0257

Middle School
Health Office
508-998-0267

MEDICATION ORDER

TO BE COMPLETED BY A LICENSED PRESCRIBER
(Physician, Nurse Practitioner or others authorized by Chapter 94C)

Name of Student _____ Date of Birth _____

Address _____
(street) (city/town)

Name of Licensed Prescriber _____ Title _____

Business Telephone Number _____ Emergency Telephone Number _____

Medication _____

Route of administration _____ Dosage _____

Frequency _____ Time(s) of administration _____

Please note:

1. Whenever possible, medication should be scheduled at times other than school hours.
2. Over the counter medication will require a written order to be administered in school.

Specific directions or information for administration _____

Date of Order _____ Discontinuation Date _____

Diagnosis* _____

Any other medical condition(s)* _____

Additional Information

1. Special 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

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AUTHORIZATION FOR DISPENSING MEDICATION
(ONLY NEEDED IF YOUR CHILD REQUIRES REGULAR MEDICATION)

Name of Student _____ Sex _____ Date of Birth _____

Name of Parent/Guardian _____

Address _____

Tel. Number (home) _____ Tel. Number (work) _____

Other persons, if any, to be notified in case of emergency if parent/guardian is unavailable:

Name _____ Telephone _____

Relationship _____

My son/daughter is currently receiving the following medication (to be completed if not in violation of confidentiality.) Please list all medications the child is receiving, including those given during the school day:

My son/daughter is known to have the following allergies:

I give permission to have the school nurse give the following medication(s) _____
Name of medication(s)

prescribed by _____ to _____
Doctor or Licensed Prescriber Name of Student

I give permission for my son/daughter to self-administer medication if the school nurse determines it is safe and appropriate.

Yes [] No []

I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within one week following termination of the order or by the last day of school.

I understand that the school nurse may share with appropriate school personnel information relative to the prescribed medication administration, e.g., adverse side effects, as she/he determines necessary for my son's/daughter's health and safety. (If you object, please contact the school nurse)

Signature of Parent/Legal Guardian _____

Relationship to Student _____ Date _____