Whitin Intermediate School

Medication Administration Order

120 Granite St, Uxbridge, MA 01569 508-278-6361(Nurse) 508-278-8639(Fax) Email: kgauthier@uxbridge.k12.ma.us

For Licensed Prescriber: (please complete)

Student Name:_____ DOB:_____

Diagnosis:_____

Medication: (dosage, route, frequency)_____

Discontinue Date:_____

Consent for self-administration(provided the school nurse determines it is safe and appropriate) Yes_____ No_____

Signature of licensed prescriber_____ Date:_____

Parent/Guardian Consent: (please complete)

Student Name:_____

I give permission to have the school nurse or school personnel designated by the school nurse to administer the above medication to my student at school.

I give permission for my child to self-administer medication if the school nurse determines it is safe and appropriate and authorized by the licensed prescriber. Yes_____ No_____

I give permission for the school nurse to share with the appropriate school personnel information relative to the prescribed medication, i.e. adverse side effects, as she determines necessary for the child's health and safety. Yes_____ No_____

Allergies_____

Parent/Guardian Signature_____Date:_____