Falmouth Public Schools
Parent/Guardian Medication Consent Form
(For the Administration of Medication)

Student's Name: ____ Date of Birth: _______________________

Teacher: ____

Parent/Guardians Name: ____

Home Phone: __________________________ Cell Phone: _________________ Emergency Phone: _____________

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

Name: ______________________________ Phone: _______________________ Relationship: ________________

I give my permission to have the school nurse, or school personnel designated by the school nurse, give the following

Medication: ___________________ Dosage: ______________ Frequency: _________Time to be given: _________
Please note: whenever possible, medication should be scheduled at times other than school hours.

Date to start: ________________________________ Date to stop: ______________________________________

Name of Licensed Prescriber: ____

My child is currently receiving the following medications. Please list ALL medications with dosage including those given in school.

1 ___________________________ 2 ______________________________ 3 ___________________

4 ___________________________ 5 ______________________________ 6 ___________________

I give permission to the school nurse to give the above medication to my child. I am aware that should the school nurse not be available to give this medication, I will be notified.	Yes	No
I give permission to the school nurse to share with the licensed prescriber information relative to the prescribed medication administration, e.g. effectiveness, adverse side effects, as she/he determines necessary for my child's health and safety.	Yes	No
I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medication administration *, e.g. adverse side effects, as she /he determines necessary for my child's health and safety. (If not in violation of confidentiality)	Yes	No
I give permission for my son/daughter to self-administer their metered dose inhaler, if the school nurse determines it is safe and appropriate and with permission of the prescribing physician.	Yes	No
I understand that if my child's class has a field trip or overnight class trip the teacher will be responsible to administer the medication.	Yes	No
I understand that I may retrieve the medicine from school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order or by the last day of school.	Yes	No

Signature of Parent/Guardian: ____

Relationship to Student: ___________________________ Date: __________________

Falmouth Public Schools
Physician's Medication Order
(To be completed by a Licensed Prescriber Physician, Nurse Practitioner or other authorized by Chapter 94C)

Student's Name: ______________________________________ **Date of Birth:** ______________________

Name of Licensed Prescriber: ____________________________ **Title:** _____________________________

Business phone: _______________________________________ **Emergency phone:** ___________________

Medication: ____

Route of Administration: _______________________________ **Dosage:** ____________________________

Frequency: ____ **Time of administration:** ______________
(Please note: whenever possible, medication should be scheduled at time other than school hours)

Specific directions or information for administration:

____

Date ordered ____________________________________ **Discontinuation date** _________________

*** Diagnosis**

____

*** Any other medical conditions**

____

____

Special side effects, contra-indications, or possible adverse reactions to be observed: ____________________

____

Other medications being taken by student: ____

____

Date of next scheduled visit or when patient is advised to return to prescriber: __________________________

The parent may request that a missed morning dose or a dose needed due to an extended day be given by the school nurse/designee.	**Yes**	**No**
I give consent for self-administration of this medication provided the School Nurse determines it is safe and appropriate.	**Yes**	**No**
In the event that there is no nurse on duty, this student may self-administer his/her inhaler should it be necessary.	**Yes**	**No**

Signature of Licensed Prescriber: ____________________________________ **Date:** ________________

*** Please provide if not in violation of confidentiality**