Somerville School Health

Health Provider Medication Order and Parental Consent

Dear provider: Prescription medication can only be given if this form is fully completed. Whenever possible please prescribe medication during non-school hours so the parent/guardian and not school staff administer the medication.

Name of Student _____ Date of Birth _____Grade_____

Address _____

Name of Licensed Prescriber _____ Phone number _____

Medication _____ Dosage _____Times given_____

Route of Administration : PO topical Inhalation SQ IM Gtts Other: _____

Additional administration orders: _____

Date of Order _____ Discontinuation Date _____

1. **Possible side effects/adverse reactions or contraindications**: □ None □ Rash □ Hyperactivity □ Lethargy
   □ Headache □ Poor appetite □ Poor sleep □ GI symptoms □ Tremor □ Other: _____
2. **Action School nurse should take if side effect occurs**: □ Stop medication □ Notify parent/guardian
   □ Notify health provider immediately □ Seek immediate treatment □ Other: _____
3. **Other medication** being taken by the student: _____
4. Date of next **follow up visit** □ scheduled □ recommended: _____
5. **Other health problems**:_____ **Allergies:** _____

_____ _____

Signature of Licensed Prescriber Date

PARENT/GUARDIAN AUTHORIZATION FOR PRESCRIPTION MEDICINE

Parent/Guardian Name (1)_____ (2)_____

(1) Telephone number --Home: _____ Work: _____Other:_____

(2) Telephone number --Home: _____Work: _____Other:_____

Other person(s) to be notified in case of medication emergency:

Name: _____ Telephone number: _____

I consent to have the school nurse or school personnel designated by the school nurse administer this medication:

Yes _____ No_____

I consent to have my child self administer the medication (provided the school nurse determines it is safe and appropriate):

Yes_____ No_____

I give permission to the school nurse to share information relevant to the prescribed medication administration to other health care/school personnel as s/he determines appropriate for my child's health and safety. Yes____ No____

I give my consent to have my child photographed to attach to the medication order for identification purposes. Yes____ No____

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 by the last day of school.

Parent/guardian Signature_____ Date _____

DS 3/02