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: _____ DOB: _____ Grade_____

Address: _____

Name of Prescriber: _____MD Phone #_____

Medication: _____Dosage _____Time 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. Actions 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 concerns: _____Allergies_____

_____ _____

Signature of Licensed Prescriber **Date**

PARENT / GUARDIAN AUTHORIZATION FOR PRESCRIPTION

PARENT / GUARDIAN NAME (1)_____(2)_____

1. Phone number-Home_____Work_____Cell_____

2. Phone number-Home_____Work_____Cell_____

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

Name: _____Telephone number:_____

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

Yes _____ No_____

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

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 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_____