Westford Public Schools

Medication Administration Form

In order to administer a daily medication to your child, this information must be completed and signed by the appropriate personnel and returned to the school nurse.

Student Name: _____DOB:_____ Grade:_____

Parent/Guardian Name(s): _____

Home Phone #:_____ Work : _____ Cell #:_____

Name of Prescriber:_____ Telephone #:_____

In case of emergency and parents cannot be reached call:_____

Home phone # _____ Work # _____ Cell # _____

Diagnosis:_____

Food-drug allergies (state reaction): _____

Medication to be taken: _____

Dose:_____Frequency:_____Time:_____Location:_____

Date ordered: _____ Duration:_____

Specific directions (ie w/ food, on empty stomach):_____

Side effects:_____

All medication must be stored in a prescription bottle labeled by the pharmacy.

Permission:

I consent to have the school nurse or school personnel, designated by the school nurse, administer the above medication. I give permission for the school nurse to share information relevant to the prescribed medication as determined appropriately for my student's health and safety. _____

Guardian Initials

Medication should be sent and administered on field trips: ❑ **Yes** ❑ **No**

Child can self-administer medications: Parents ❑ **Yes** ❑ **No**

Child can self-administer medications: Physician ❑ **Yes** ❑ **No**

Child can self-administer medications: School Nurse ❑ **Yes** ❑ **No**

Parent/Guardian signature: _____ Date:_____

Physician signature: _____ Date: _____

School Nurse signature: _____ Date:_____

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