SOMERSET PUBLIC SCHOOLS
School Health Services

Medication Order/Parental Consent for Administration of Medication
(Based on 105 CMR 210.000)

DATE: _____

SCHOOL: _____ GRADE: _____

REQUEST FOR GIVING MEDICATION AT SCHOOL:

1. PARENT/GUARDIAN SECTION: (to be filled out completely and signed)

I hereby request the School Nurse see that my child: _____ receives the medication prescribed by: _____ for the period from: _____ to _____.

Medication will be supplied by parent/guardian of the child in the original pharmacy or manufacturer labeled container with the child's name, name of medication, dosage, route and time that the medication is to be given. The medication will be delivered to the School Nurse by the parent/guardian.

***I give permission for my child to self-carry/self-administer INHALER or EPI-PEN during field trips ONLY, if School Nurse and/or Physician determine it is safe and appropriate: YES NO**

_____ /_____
PARENT/GUARDIAN'S NAME (PLEASE PRINT) PARENT/GUARDIAN'S SIGNATURE

Home: _____ Work: _____ Cell: _____

Emergency Contact if parent/guardian unavailable: _____
(NAME/TELEPHONE NUMBER)

2. PHYSICIAN/LICENSED PRESCRIBER SECTION: (to be filled out completely and signed)

The above-named child is under my care. Please administer medication as prescribed by me.

NAME OF MEDICATION: _____

DOSAGE: _____ **ROUTE:** _____

FREQUENCY/TIME(S) TO BE GIVEN AT SCHOOL _____

SPECIFIC DIRECTIONS: _____

DURATION OF TREATMENT: _____ /_____
(START DATE) (END DATE)

DIAGNOSIS: _____

***It is safe and appropriate for the above mentioned student to self-carry/self-administer INHALER or EPI-PEN during field trips ONLY: YES NO**

PHYSICIAN'S NAME: _____
(PLEASE PRINT)

PHYSICIAN'S SIGNATURE: _____

ADDRESS: _____

_____
(CITY) (STATE) (ZIP) (TELEPHONE)