The City of Lowell • Health Department
341 Pine Street • Lowell, MA 01851
P: 978.674-4305 • F: 978.446-7100
www.LowellMA.gov

PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION AND MEDICATION ADMINISTRATION PLAN

Name of Student: _____ DOB: _____ Sex: _____

School: _____ Grade: _____

Name of Parent/Guardian: _____

Telephone (Home): _____ (Work): _____ (Cell): _____

Other person to be notified in case of emergency if parent unavailable: (Need at least two other names)

Name: _____ Telephone: _____ Relationship: _____

Name: _____ Telephone: _____ Relationship: _____

My child is currently receiving the following medications:

1. _____ 2. _____ 3. _____ 4. _____

My child has the following allergies _____

I give permission for the school nurse or school personnel designated by school nurse to give the following medication:

_____ Prescribed by: _____

I give permission for my child to self-administer medication if the school nurse determines it safe and appropriate: YES/NO (Circle One)

I give permission for the school nurse to share with appropriate school personnel information relative to the prescribed medicine administration (e.g. adverse side effects, as she/he determines necessary for my child's health and safety). YES/NO (Circle One)

I have reviewed the Medication Administration Plan on the back of this page and I am in agreement with it. YES/NO (Circle one)

Parent/Guardian Signature: _____

Date: _____

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PLEASE NOTE THE FOLLOWING:

In order to assure safe medication administration, I understand that a picture of my child will be attached to the medical record.

MEDICATION ADMINISTRATION PLAN

Student Name_____

Medication_____

Possible Side Effects_____

Special Directions_____

_____

Quantity of medication received by school is recorded on medication sheet.

Storage in locked medicine cabinet_____ Refrigerator_____Unlocked drawer or cabinet _____

Delegated to substitute nurse or school medication delegates.

Medication will be administered in health room unless otherwise specified in special directions.

Field Trip Plan: If parent/guardian does not attend the field trip with their child, his/her medication will be delegated by the nurse to a responsible faculty/staff member who will be attending the field trip. The nurse will give the medication to this delegated person who will administer the medication to your child. Not all medications can be delegated to school personnel. Please see your school nurse for clarification.

Parent/Guardian Initials_____ Date:_____

Signature of School Nurse_____

The City of Lowell • Health Departmer
341 Pine Street • Lowell, MA 018
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MEDICATION ORDER

(To be completed by a Licensed Prescriber: Physician, Nurse Practitioner, Or others authorized by Chapter 94C)

Name of Student_____ Date of Birth_____

Address_____ Grade_____

Name of Licensed Prescriber_____ Title_____

Business Telephone #_____ Emergency Telephone #_____

Medication_____

Route of Administration_____ **Dosage**_____

Frequency_____ **Time(s) of Administration**_____
(Please note: Whenever possible, medication should be scheduled at times other than school hours.)

Specific directions or information for administration:_____

Date of Order:_____ Discontinuation Date:_____

Diagnosis_____

Any other medical condition(s)_____

Special side effects, contraindications, or possible adverse reactions to be observed:

_____

Other medication being taken by student:_____

The date of the next scheduled visit or when advised to return to prescriber:_____

_____
Signature of Licensed Prescriber