Horace Mann Middle School
224 Oak Street
Franklin, MA 02038
508-541-6230
Fax-508-541-7071

Shawn Fortin,
School Principal

Kym Cameron, RN
School Nurse

Medication Order Form
(One form per medication)
To be Completed by Licensed Prescriber

Student Name ________________________________ Age __________ Grade _______
Diagnosis ____

Medication ____________________________________ Dosage ___________________
Route ____ Frequency ________________
Specific Directions ____
Date of Order __________________________ Discontinue Date ___________________

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

Consent for self administration (provided the school nurse determines it safe and appropriate) Yes _______ No _______

Other medical conditions __________________________ Allergies ________________

_______________________________________ ___________________
Signature of Provider Date

____ ___________________
Print Name of Provider Telephone Number

Written Parent/Guardian Consent

Name of Parent/Guardian ____

- I give my permission to have the school nurse, or designated personnel, give the following medication _________________________ to my child.
- I give permission for my child to self administer medication if the school nurse determines it is appropriate. Yes ______ No _______
- I give the school nurse permission to share with appropriate school personnel, information relative to the prescribed medication. Yes _______ No _______

I understand that I may retrieve the medicine from school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order, or one week beyond the close of school.

________________________________ ____________
Parent/Guardian Signature Date