

*Jefferson Elementary School
628 Washington Street
Franklin, MA 02038
508-541-2140
Fax: 508-541-2124*

*Jane Hyman,
Principal*

*Leslie McInnis, 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 _____ Tel. Number _____

- 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