

*Oak Street Elementary School  
224 Oak Street  
Franklin, MA 02038  
508-541-7890  
Fax-508-541-8047*

*Corine Minkfe  
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 \_\_\_\_\_