

Gerald M. Parmenter School
235 Wachusett Street
Franklin, MA 02038
Telephone: (508) 541-5281 Fax: (508) 553-0894

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 _____