Annie Sullivan Middle School
500 Lincoln Street
Franklin, MA 02038
Tel. 508-533-0322 Fax 508-541-2109

Beth Wittcoff
Principal

Marguerite Almanas, 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

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 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