

Danvers Public Schools
Medication Administration Plan and Parent Authorization

Student Information	
Student :	DOB :
1.Parent/Guardian :	Phone :
2.Parent/Guardian :	Phone :
Prescriber :	Phone :

Medication Administration Plan <i>*For nurse to fill out*</i>			
Diagnosis :		Medication :	Ex:
Dose :	Freq. :	Route :	Time :
<u>Specific Directions for medication administration :</u> <u>Quantity of medication received/Date received:</u> <u>Potential side effects of medication :</u> <u>Required storage conditions :</u> <u>Plan for field trip medication administration :</u> <u>Other medications taken by student if not in violation of confidentiality :</u> <u>Allergies:</u> <u>Duration of Order:</u> School Year			

Parent/Guardian Authorization		Initial
I consent to have the school nurse (or school personnel designated by the school nurse) administer the medication prescribed above to my student	☐ Yes ☐ No	
I give permission for my child to self-administer medication, if the school nurse determines it is safe and appropriate	☐ Yes ☐ No	
I give permission for the school nurse to attach a photograph of my child to the student health record for identification purposes.	☐ Yes ☐ No	
I give permission for the school nurse to share information with prescribing providers and school staff relative to the prescribed medication as the school nurse determines appropriate for my child's health and safety.	☐ Yes ☐ No	

**I understand that I may retrieve the medication from school at any time; *however*, the medication will be destroyed if it is not picked up by the end of the school year.

Parent/Guardian signature : _____ Date : _____
 Nurse Signature: _____ Date: _____