Plymouth Public Schools

Parent/Guardian Consent for Medication Administration

Student: _____ ☐ **Male** ☐ **Female**

Date of Birth: _____ **Grade:** _____ **Date of Consent:** _____

My son/daughter is known to have the following **allergies**:_____

_____

Diagnosis (if not in violation of confidentiality): _____

_____

1. I request and give permission to the school nurse to give my son/daughter:

   Medication: _____ Dosage: _____

   Route: _____ Time of Day: _____

   Prescribed by: _____

2. I give permission for my son/daughter to self-administer (**carry the medication and administer by him/her-self during class/field trip**) **NOT** in the presence of the school nurse. **Note:** Self administration is reserved for students who have an Epi-pen, enzyme supplement, inhaler or diabetic supplies as per the regulations of the Commonwealth of MA. ☐ **Not Applicable** ☐ **Yes** ☐ **No**

   If I give my permission, I understand the school nurse and I must be in agreement that my student demonstrates the ability and understands all aspects of administration of this medication as directed. I also agree to provide a back-up supply for the nurse to keep in the health office in the event my student does not have his/her prescribed medication/supplies in his/her possession when needed.

3. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medicine administration as s/he determines necessary for my child's health and safety. ☐ **Yes** ☐ **No**

4. I understand that in the event of a field trip, this medication administration plan may need to be adjusted and I will do the following:
   - ☐ Call the school nurse prior to the field trip to discuss the plan for administering this medication
   - ☐ This medication may be withheld (not given) on the day of the field trip.
   - ☐ Not Applicable - Self administration selected in #2 above

5. I understand that I may retrieve the medicine from the school at any time, and that the medicine will be destroyed if it is not picked up within one week following the termination of the order or the last day of school.

Parent/Guardian Signature: _____ **Date:** _____

Student Name: _____

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MEDICATION ADMINISTRATION PLAN (To be completed by the School Nurse)

Medication: _____ **Duration of Medication:** _____

Date Ordered: _____ **Expiration Date of Medication:** _____

Time to be Given: _____ **Quantity Received:** _____

Contraindications/Side Effects: _____

_____

_____

_____

Onset/Peak/Duration: O: _____ **P:** _____ **D:** _____

Refrigeration: ☐ **Yes** ☐ **No**

IHCP Indicated: ☐ **Yes** ☐ **No**

Original MD order received: ☐ **Yes** ☐ **No**

Entered into Health Office Computerized Database: ☐

Medication Administration record completed and placed in medication book: ☐

School Nurse Signature: _____ **Date:** _____

Medication may be given 30 minutes before or after scheduled time; or at an alternate time if school schedule or activities change.