ASHLAND PUBLIC SCHOOLS

LICENSED PRESCRIBER ORDER

(To be completed by Physician,
Nurse Practitioner, or other authorized by Chapter 94C)

Student Name____ DOB________________ Grade / Room ____________________

Licensed Prescriber (Print) ____

Telephone ___________________________________ FAX_____________________________

Diagnosis*____ **Allergies**: ____

Medication Dose Route Frequency Time

1.____

2.____

3.____

4.____

Possible side effects:____

Student may self administer if School Nurse determines it is safe and appropriate: YES_____NO_____

NOTE: *Whenever possible, medication should be given at home to avoid school hours*

Prescriber's Signature_________________________________ Date _____________ Stamp

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PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

I give permission for the School Nurse to administer the following medicine(s), as prescribed by ____________________________
to my child____

1.____ 3.____

2.____ 4.____

Other medications my child currently takes *

Drug____ Dose_______________________ Frequency_________________________

Drug____ Dose_______________________ Frequency_________________________

Drug____ Dose_______________________ Frequency_________________________

Permission for teacher or designated adult to administer during field trips………….……YES________NO_______

Permission to share pertinent medication information with appropriate school personnel: YES________NO_______

Permission to self administer if the School Nurse determines it is safe and appropriate: YES________NO_______

I will supply medication in a labeled original pharmacy container. I understand that the school may store <u>*only a 30 day supply*</u> *of medication. The medication will be destroyed if it is not picked up by the last day of school.*

Parent / Guardian (Print) ____

Parent / Guardian Signature____ Date______________________

Phones: Home_____________________________ Work ____________________________ Cell _____________________________

**If not a violation of confidentiality*