Sturgis Charter Public School

An International Baccalaureate Diploma School

Medication Administration Consent and Order Form

Student's name: _____Grade: _____ Date of birth: _____
Address: _____
Parent/Guardian name: _____ Primary telephone: _____
Allergies: _____

Name of licensed prescriber: _____ Title: _____ Telephone: _____
Name of medication: _____ Dose: _____
Route of administration: _____ Frequency: _____
Time of administration during the school day: _____

Parent/Guardian:

1. I consent to have the school nurse or school personnel designated by the school nurse to administer the medication to the Sturgis Charter School student and as prescribed by the licensed prescriber named above.
2. I give permission for my son/daughter to self-administer the above named medication if the school nurse deems it is appropriate. ____ Yes ____ No
3. I give permission to the school nurse to share information relevant to the medication, medication administration, and associated medical condition as appropriate for my son's/daughter's health and safety.
4. I give permission to the school nurse to delegate medication administration to another appropriate staff member for school sponsored field trips.
5. I give permission to the school nurse to forward this form to the licensed provider named above for completion.

Parent/Guardian Signature: _____ Date: _____

Licensed Prescriber:

1. Diagnosis if not in violation of confidentiality:_____
2. Other medical conditions if not if violation of confidentiality: _____
3. Other medications being taken by the student: _____
4. Order date: _____ Discontinue date: _____
5. Specific directions for medication administration:_____
6. Please specify any side effects, contraindications, or possible adverse reactions to monitor for:

_____

7. Provided the school nurse deems it appropriate, the student may carry and self-administer the above named medication. ____ Yes ____ No
8. Student is scheduled for follow up at intervals of _____ to monitor use and effectiveness of the medication named above.

Signature of licensed provider: _____ Date: _____

East- 427 Main Street, Hyannis, MA 02601 Tel: (508) 778-1782 Fax: (508) 775-3163
West-105 West Main Street, Hyannis, MA 02601 Tel: (508) 771-2780 Fax: (508) 771-1293