Westfield Public Schools
Medication Order, Parent Consent, and Administration Plan

Student's Name_____ Date of Birth_____ Allergies_____

School_____ Grade_____ Teacher_____

I. Prescriber's Order

The following to be completed by the licensed prescriber as authorized by Chapter 94C:
Whenever possible, all medications will be scheduled outside school hours.

Name of medication:_____ Dose_____Route_____Time_____

Diagnosis for medication given:_____

Significant Side Effects_____

Monitoring required for side effects_____

Start Date_____ Discontinue Date_____

Other Information_____

Printed name of licensed prescriber_____ Date_____

Signature of licensed prescriber_____Office phone number_____

II. School Nurse Medication Administration Plan

Can the student self-administer if determined appropriate by the nurse? _____Yes _____No

Self-administration plan_____

Will the scheduled medication be administered on early release school days? ____Yes ____No

Field trip plan/Delegation_____

III. Parent Consent

Name of Parent/Guardian_____

List all medications the student is currently taking_____

I request the above named student be administered the medication as ordered by the prescribing provider and as authorized by myself. I understand that I may pick up the medication at any time, and the medication will be disposed of according to state regulations if not picked up by dismissal on the last day of school.

_____ _____ _____
Signature of parent/guardian Phone Date

_____ _____
Signature of student (Self Administration Plan Only) Date

School Nurse Signature_____ Date_____