

THE PUBLIC SCHOOLS OF BROOKLINE
SCHOOL HEALTH SERVICES
Parent Form
MEDICATION ADMINISTRATION PLAN

Name of Child _____ Sex [] Date of Birth _____ School _____ Grade _____

Parent/Guardian _____ Home Phone _____

Work Phone _____ Emergency Phone _____

Other person(s) to be notified in case of medication emergency:

Name _____ Phone _____

Name _____ Phone _____

My child currently has the following health issue/diagnosis(s)*:

My child is currently receiving the following medication(s)*: _____

My child has the following food and/or drug allergies: _____

I give permission for the School Nurse or school personnel designated by the School Nurse to administer to my child

Medication: _____ Dose: _____ Place to be given: _____

Specific directions, e.g. times: _____

possible side effects, adverse reactions: _____

prescribed by: _____ address: _____ phone: _____.

YES NO

____ My child requires medication to be given during field trips (to be given by teacher or designated staff).

____ My child requires medication to be given on early release days.

____ My child may self-administer medication if the school nurse determines it safe and appropriate.

____ I give permission for the school nurse to share information relevant to the prescribed medication administration as appropriate for my child's health and safety.

Quantity of medication received/date: _____ Required storage _____

I understand I may retrieve the medication from the school at any time: *however, the medication will be destroyed if it is not picked up with n one week following termination of the order, transfer of student or one week beyond the close of school.*

Signature of School Nurse _____ Date _____

Signature of Parent/Guardian _____ Date _____

Signature of Student, if appropriate _____ Date _____

*If not in violation of confidentiality.