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 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 asthma and/or emergency allergic 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 or one week beyond the close of school.*

Signature of School Nurse _____ Date _____

Signature of Parent/Guardian _____ Date _____

Signature of Student, if appropriate _____ Date _____

See back for plans for teaching self-administration _____, delegation _____, monitoring _____, other _____.

*If not in violation of confidentiality.

1/03