

**ST. PATRICK SCHOOL
PARENT/GUARDIAN CONSENT / MEDICATION ORDER**

Student Name:	DOB:	Grade:	Circle: A or B	
Allergies:	Medication List:	Medical History:		
Parent/Guardian Name:				
Home phone:		Cell Phone:	Work Phone:	
Other person(s) to be notified in case of medication emergency:				
Name:		Phone Number:		
Please CIRCLE any of the following standing order medications approved by our school physician, which you permit the RN to administer to your child while at school. Oral medications: Acetaminophen (Tylenol) Ibuprofen (Motrin) Calcium Carbonate (TUMS) Diphenhydramine (Benadryl) Eye Wash: sterile, buffered, isotonic saline Topical medications: Bacitracin ointment Calamine lotion				
I give permission to have the school nurse give my child the following prescription/OTC medication(s) as ordered by doctor (pg.2) _____ Please note: whenever possible medication should be scheduled at times other than school hours. Other side of form needs to be completed to administer prescription and OTC medications not included in above standing order medications.			YES	Initial
I give permission for my child to receive a non-mentholated, sweetened cough drop.			YES	NO
I give permission to the school nurse to share information relevant to my child's health and safety with administration, faculty and/or staff as she determines appropriate. This includes teacher notification of possible side effects of medication. A parent provided photo attached to Epi-Pen Boxes is highly recommended.			YES	NO
I give permission for my child to self-administer his/her rescue inhaler on field trips or parent/guardian has the option of attending fieldtrip to administer medication.			Please initial	
Parents of students who receive daily medications at school have the option of attending field trips to administer medications to their child or they may contact child's doctor for order stating student may self administer medication on field trip if deemed appropriate by physician and agreed upon by parent and school nurse.			Please initial	
ADDITIONAL IMPORTANT MEDICAL REQUIREMENTS: All medications including EpiPens and Inhalers need to be brought to the nursing office in their original container with a prescription label with a valid expiration date .				
Every effort will be made to have full-time school nurse coverage. In the very unlikely event a nurse is not available, the parent/guardian of the child who requires daily medications or monitoring at school, and those children requiring immediate use of rescue inhalers (who do not have parental consent to self-administer their medication), will be notified. At such times, those parents/guardians have the option of administering medication or to pick up your child when a nurse is not available.				
All prescription and over-the-counter medication will be kept at the nurse's office and administered under the nurse's supervision with the exception of inhalers and EpiPens, which the students are required to have on his/her person at all times (per Asthma and Allergy Acknowledgment Forms).				
I understand I may pick up the medication from the school at any time during the school day; however, the medication will be destroyed if it is not picked up within one week following termination of the order or 48 hours beyond the close of school.				
Signature of Parent/Guardian				Date

ST. PATRICK SCHOOL MEDICATION ORDER

To be completed by a Licensed Prescriber, Physician, Nurse Practitioner, or others authorized by Chapter 94C

Name of Student: Date of Birth:

Address: Grade:

Name of Licensed Prescriber: Title:

Business Telephone: Emergency Telephone:

Medication:

Route of Administration: Dosage:

Frequency: Time(s) of administration:

(Please note: Whenever possible, medication should be scheduled at times other than school hours.)

Date of order; (mm/dd/yyyy)

Diagnosis (if not a violation of confidentiality):

Any other medical conditions):

Any food or **drug allergies:**

Specific directions or information for administration:

Optional Information:

Special side effects, contraindications, or possible adverse reactions to be observed:

Date of next scheduled visit or when advised to return to prescriber:

Signature of Licensed Prescriber **Date**

Signature of Parent/Guardian **Date**