

SALEM PUBLIC SCHOOLS HEALTH SERVICES: MEDICATION ADMINISTRATION CARE PLAN

STUDENT NAME _____ BIRTH DATE _____ PARENT/GUARDIAN NAME _____

SCHOOL _____ GRADE _____ HR # _____ TELEPHONE # _____ EMERGENCY # _____

EMERGENCY CONTACT PERSON _____ TELEPHONE # _____ RELATIONSHIP _____

NAME OF LICENSED PRESCRIBER _____ TELEPHONE # _____

PCP(IF DIFFERENT) _____ TELEPHONE # _____

DIAGNOSIS * _____ OTHER MEDICATIONS BEING TAKEN BY STUDENT * _____

FOOD / DRUG ALLERGIES _____ * IF NOT IN VIOLATION OF STUDENT'S CONFIDENTIALITY

** **MEDICATION** _____ EXPECTED ACTION _____

DOSAGE _____ **FREQUENCY** _____ **ROUTE** _____ **SPECIFIC DIRECTIONS** _____

DATE ORDERED _____ EXP. DATE _____ REQUIRED STORAGE _____ *double locked cabinet*

POSSIBLE SIDE EFFECTS / ADVERSE REACTIONS _____

LOCATION WHERE MEDICATION ADMINISTRATION WILL OCCUR: HEALTH OFFICE _____ OTHER (SPECIFY) _____

FIELD TRIP PLAN: _____ PLANS FOR TEACHING SELF ADMINISTRATION: _____

CONSENT

For the safety of your child, a current photograph will be kept on file for positive identification.

1. I give permission to have the school nurse administer the following medication _____ prescribed by _____
(Name of Medication)
_____ to _____
(Licensed Prescriber) (Student's Name)

2. I give permission for my son / daughter to self administer medication if the school nurse and his / her licensed prescriber determine that it is safe and appropriate.
YES _____ NO _____

3. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medication administration.
YES _____ NO _____

RESTRICTIONS _____

PARENT / GUARDIAN SIGNATURE: _____ DATE _____

STUDENT'S SIGNATURE, IF APPROPRIATE _____ DATE _____

(Please note: I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within one week following termination of the order or on the last day of school.)

