**SAINT BRIDGET SCHOOL**
832 Worcester Road
Framingham, MA 01702
P: (508) 875-0181 F: (508) 875-9552

## PRESCRIPTION AND OTHER MEDICATIONS

Massachusetts State Law requires that the following forms must be on file in your child's health record before we begin to give any prescription medicine at school. **1)** Signed consent by the parent or guardian to give the medicine. **2)** Signed medication order by the licensed prescriber. These forms "must" be renewed as needed and at the beginning of each school year. **3)** Over the counter medications only required parent signed consent.

You or another responsible adult whom you designate should deliver medicines to the school in a pharmacy or manufacturer- labeled container. Please ask your pharmacy to provide separate bottles for school and home. No more than thirty days supply of the medicine should be delivered to school at a time.

When your child needs a medicine to be given during the school day, please act quickly to follow these policies so we may begin to give the medication as soon as possible. Thank you for your help.

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

Name of Student: _____ Grade: _____ DOB _____ Sex _____

Address _____
*(Street)* *(City/Town)* *(Zip)*

Name of Licensed Prescriber _____ Title _____

Bus. Tel. No. _____ Emergency Tel No. _____

Medication _____

Route of Administration _____ Dosage _____

Frequency _____ Time(s) of Administration _____
*(Please note: Whenever possible, medication should be scheduled at times other than school hours).*

Specific directions or information for administration: _____

Date or Order _____ Discontinuation Date _____

Diagnosis _____

Consent for self administration (provided the school nurse determines it is safe and appropriate) **Y** _____ **N** _____

_____
Signature of Licensed Prescriber

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## PARENTAL CONSENT

1. I give permission to have the school nurse or school personnel designated by the school nurse give the following medicine _____
(Name of Medicine and Dose)

   prescribed by _____ to _____
(Licensed Prescriber) (Name of Student)

2. I give permission for my son/daughter to self-administer medication if the school nurse determines 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 medicine administration, e.g., adverse side effects as he/she determines necessary for my son's/daughter's health and safety. Yes _____ No _____ Any restrictions on release _____.

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

   Signature of Parent/Guardian _____

   Relationship to Student _____ Date _____