FRANCIS W. PARKER CHARTER ESSENTIAL SCHOOL
& THEODORE R. SIZER TEACHERS CENTER
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NURSE'S FAX: (978) 772-9494

Medication Order and Parent/Guardian Consent Form

Under Massachusetts General Laws (MGL) Chapter 112, Section 80B, a licensed nurse must have a medication order from a physician, dentist, nurse practitioner, or physician's assistant in order to administer any prescription medication and any over-the-counter (OTC) medication not covered by the Parker School standing orders provided by the school physician.

Licensed Prescriber's Written Medication Order:

Student name: _____ Grade: _____ DOB: _____

Medical diagnosis: _____

Medication: _____ Dose: _____

Route: _____ Frequency: _____ Time to Administer at School: _____

Start date: _____ Duration of order: (all orders expire at the end of the school year) _____

Allergies/Comments: _____

Consent for Self-Administration of Medication (provided the School Nurse determines it is safe and appropriate):
◯ Yes ◯ No

Signature of Licensed Prescriber: _____, MD, NP, Other ____

Print Name: _____ Tel: _____ Date: _____

Parent/Guardian Consent: Complete each statement.

- I, the undersigned, give permission to the School Nurse to administer the above named medication to my child. I have read and understand the Medication Administration in the School Setting Policy. I understand that the school personnel are not responsible for any problems arising from the use of this medication, its side effects or for the omission of the medication. I further agree to indemnify and hold harmless the Board of Trustees, against all claims as a result of any or all acts performed under this authority.
  ◯ Yes ◯ No
- I give permission to the School Nurse to share information relevant to the prescribed medication administration as determined appropriate for my child's health and safety.
  ◯ Yes ◯ No
- I give permission for my child to self-administer the prescribed medication if the School Nurse has determined it is safe and appropriate.
  ◯ Yes ◯ No

I understand that I may retrieve the medication from school at any time; however, the medication will be destroyed if it is not picked up within one week following the termination of the order or the last day of school, whichever occurs first.

Parent/Guardian Signature: _____

Print Name: _____ Tel: _____ Date: _____

NOTE: First fill out this document then print it and bring it to the student's licensed healthcare provider to sign. Once signed, return this document to the Health Office. This can also be uploaded to the portal.