cCann Technical School

Northern Berkshire Vocational Regional School District

Medication Plan and Consent Form

Student Name: ______________________________ **Grade**: __________ **Date of Birth**: ____________

Completion of this form by the student's medical provider and parent/guardian is required for any medication to be dispensed in school. Under Massachusetts General Laws chapter 112, 80B, a licensed nurse must have a medication order from a physician, dentist, nurse practitioner, or physician's assistant in order to administer any medication, whether it is a prescription drug or over-the-counter medication. All prescribed medications must be delivered to the nurse's office in the original pharmacy labeled container by an adult 18 years or older. Any over-the-counter medications must be in their original packaging. Medications will be disposed of if they are not picked up within one week following the order's termination or at the completion of the last day of school.**Please fax all forms to 413-664-9424.**

Parent/Guardian:

By signing below, I give permission for the school nurse to contact the provider completing this form if further information or clarification is needed regarding the care of my child. By signing below, I also give permission to the school nurse (or staff delegated by the school nurse) to administer to or to supervise my child in taking the medication. I understand that the school personnel are not responsible for any problems arising from the taking of this medication, its side effects (if any), or for the omission of medication. I understand that it is the responsibility of my child to report to the health office for scheduled medication administration.

Physician:

Physician Name: _______________________________________ Telephone: ____________________

Please complete and sign this form if the student must take prescribed medication during school hours and it **CANNOT** be given at home:

Diagnosis: _____________________ Medication: _____________________ Dosage: _______________

Route: _____________________ Administration Time: ________ AM ( ) PM ( ) PRN: Yes ( ) No ( )

Special Instructions/Possible Side Effect____

Date medication to begin: __________ Date medication to be discontinued: ___________ N/A ( )

**This form will be valid for the school year in which it is dated unless specific dates are required.*

This medication may be given up to 1 hour before or after scheduled administration time. If the student does not report to the health office on their own in this allotted time, the dose will be documented as "refused". The parent/guardian will be contacted for repeated refusal of medication doses.

Required Signatures:

Physician:____ Date:_____________________

Parent/Guardian: ____ Date: _____________________

Student:____Date:_____________________

School Nurse:____ Date:_____________________

Medication Administration Plan and Consent Continued

In the event of a field trip:
_____ Withhold medications during field trips
_____ I or my designee will attend my child's field trips and assume responsibility of my child's medical and medication needs.
_____*I give permission for a responsible adult trained by the school nurse to give my child their medication.

**Please note: Due to State Laws the nurse can only delegate tasks to medically unlicensed trained school personnel and cannot delegate assessment skills. Thus "as needed medications" cannot and will not be delegated (i.e. Motrin, Tylenol, Tums, Glucagon, Diastat).*

**Afternoon medication will not be administered when there is an 11:15 dismissal.*

Continued Consent:
Yes ( ) No ( ) I give the school nurse permission to share information, relative to prescribed medications, with appropriate personnel as necessary for my child's safety and health (i.e., adverse side effects).
Yes ( ) No ( ) I give the school nurse permission to speak to my child's prescriber listed on the medication order to ensure the wellness and safety of my child.

I give permission for the school nurse to give (student's name) ________________________________
his/her (name of medication) _______________________ which I will supply in its original pharmacy labeled container.

Parent/Guardian's Signature: ____________________________________**Date**: _________________

School Nurse Signature: _______________________________________ **Date**: _________________