Newburyport Public Schools

Daily/As Needed Medication Administration Form

In order to administer a daily medication to your child, this information must be completed and signed by the appropriate personnel and returned to the school nurse.

Student Name_____ DOB _____ Grade _____

Parent's name_____

Home phone # _____ Work # _____ Cell # _____

Name of Prescriber _____Telephone #_____

In case of emergency and parents can not be reached call _____

Home phone # _____ Work # _____ Cell # _____

Diagnosis _____

Food- drug allergies (state reaction): _____

Medication to be taken _____

Dose _____ Frequency _____ time _____ Location _____

Date ordered _____ Duration _____

Specific directions (ie w/ food, on empty stomach) _____

Side effects _____

All medication must be stored in a prescription bottle labeled by the pharmacy.

Permission:
I consent to have the school nurse or school personnel designated by the school nurse administer the above medication. I give permission for the school nurse to share information relevant to the prescribed medication as she determines appropriate for my child's health and safety.

Medication should be sent and administered on field trips: ❑ **Yes** ❑ **No**

Child can self-administer medications: Parents ❑ **Yes** ❑ **No**

Child can self-administer medications: Physician ❑ **Yes** ❑ **No**

Child can self-administer medications: School Nurse ❑ **Yes** ❑ **No**

Parent's signature _____ **Date** _____

Physician's signature _____ **Date** _____

School Nurse Signature _____ **Date** _____ **(rev 9_13)**