Andover Public Schools
Department of Health Services

Consent for Medication Administration

Name of Student: _____ DOB _____ Grade _____ School _____

Home Address _____ Contact# _____

MEDICATION ORDER

(to be completed by a licensed prescriber)

Diagnosis _____ **Other Medical Conditions** _____

Medication _____ **Dosage** _____ **Route** _____ **Frequency** _____

Duration _____ **Side effects** _____

Special Instructions _____

Consent for Self-Administration _____

Signature of Licensed Prescriber _____ **Date** _____

Name of Licensed Prescriber (please print) _____ **Tel#** _____

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Parent / Guardian Permission

_____ I request that the school nurse, or school personnel designated by the school nurse, administer this medication to my child.

_____ I give permission for my child to self-administer this medication if the school nurse determines it is safe and appropriate

_____ I give permission for the school nurse to share information relative to this prescribed medication with appropriate school personnel if it is necessary for my child's health and safety.

The student has the following allergies _____

The student is currently taking these other medications (including those not given at school) _____

_____

Parent / Guardian Signature _____ Date _____

Student Signature (18 yrs+) _____ Date _____

Home Tel# _____ Work Tel# _____ Cell # _____

Other person to call in emergency if parent is not available: _____ Contact # _____