

ANDOVER PUBLIC SCHOOLS
DEPARTMENT OF HEALTH SERVICES

CONSENT FOR MEDICATION ADMINISTRATION

Name of Student _____ DOB _____ Grade _____ School _____

Address _____ Tel. # _____

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.# _____

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.

This student has the following allergies _____

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

Parent / Guardian Signature _____ Date _____

Student Signature (18 yrs. old +) _____ Date _____

Home Tel. # _____ Work Tel. # _____ Cell Tel. # _____

Other person to call in emergency if parent is not available _____ Tel. # _____