BRIDGEWATER-RAYNHAM REGIONAL SCHOOL DISTRICT
HEALTH SERVICES

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Dear Parent/Guardian:

We would like to inform you of the policies that have been put in place to ensure the health and safety of children needing medicines during the school day.

Our school district requires that the following forms must be on file in your child's health record before we begin to give any medicine in school:

1. **Signed consent by the parent or guardian to give the medicine.**
   Please complete the enclosed consent form and give it to your school nurse.

2. **Signed medication order.** The written medication order form should be taken to your child's licensed prescriber (your child's physician, nurse practitioner, etc.) for completion and returned to the school nurse. This order must be renewed as needed **and** at the beginning of each academic year.

Medicines should be delivered to the school in a pharmacy or manufacturer-labelled container by you or a responsible adult whom you designate. Please ask your pharmacy to provide separate bottles for school and home. No more than a thirty day supply of the medicine should be delivered to the school.

When your child needs a medicine to be given during the school day, please act quickly to follow these policies so we may begin the medicine as soon as possible. We no longer provide lunch on scheduled early release days, therefore we will not be administering medications on those days. Thank you for your help.

Sincerely,

_____
School Nurse

_____
Telephone

_____
Fax Number

Attachments: Written Parent/Guardian Consent
Medication Order
MDPH (Form A1)
4/93

BRIDGEWATER-RAYNHAM REGIONAL SCHOOL DISTRICT
HEALTH SERVICES

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WRITTEN PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

General Information

Name of Student_____School_____Grade_____
Date of Birth_____Gender_____
Name of Parent/Guardian_____
Telephone No. (Home):_____(Work):_____
Other persons, if any, to be notified in case of emergency if parent/guardian is unavailable:
Name:_____Telephone:_____
Relationship:_____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality): (Please list all medicines the child is receiving, including those given during the school day.)
1._____2._____3._____4._____

My son/daughter is known to have the following allergies:_____
_____

CONSENT

1. I give permission to have the school nurse or school personnel designated by the school nurse give the following medicine _____prescribed by _____
(Name of Medicine) (Licensed Prescriber)
to_____.
(Name of Student)

2. I give permission for my son/daughter to self administer medication if the school nurse determines it is safe and appropriate._____YES_____NO

3. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medicine administration, e.g., adverse side effects, as she/he determines necessary for my son's/daughter's health and safety._____YES_____NO
Any restriction on release_____

4. I have been advised by my physician of all known side effects and benefits of this medicine.
_____YES_____NO

(**PLEASE NOTE:** I understand that I may retrieve the medicine from the school at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.)

Signature of Parent/Guardian_____

Relationship to Student_____ Date:_____

Form A2

BRIDGEWATER-RAYNHAM REGIONAL SCHOOL DISTRICT
HEALTH SERVICES

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MEDICATION ORDER
(To be completed by a Licensed Prescriber:
Physician, Nurse Practitioner or others authorized by Chapter 94C)

Name of Student_____Date of Birth:_____

Address:_____ Grade:_____
(street) (city/town)
Name of Licensed Prescriber:_____Title:_____

Business Telephone #_____Emergency Telephone #_____

Medication:_____

Route of Administration:_____Dosage:_____

Frequency:_____Times of Administration:_____
(**Please note:** Whenever possible, medication should be scheduled at times other than school hours.)
Specific directions of information for administration:_____
_
_____

Date of Order:_____Discontinuation Date:_____

Diagnosis:_____

Any other medical conditions *****:_____

Optional Information

1. Special side effects, contraindications, or possible adverse reactions to be observed:_____
   _____
2. Other medication being taken by student:_____
3. The date of the next scheduled visit or when advised to return to prescriber:_____
4. Consent for self-administration (provided the school nurse determines it is safe and appropriate):

   _____Yes _____No
5. Patient and family have been advised of all known side effects and benefits of this medication.

_____ _____
(date) (Signature of Licensed Prescriber)

***** If not in violation of confidentiality.

Form A3

BRIDGEWATER-RAYNHAM REGIONAL SCHOOL DISTRICT
HEALTH SERVICES

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MEDICATION ADMINISTRATION PLAN

Name of Student:_____Date of Birth:_____
Grade:_____ School:_____
Parent/Guardian Name:_____ Home Tele#:_____
Business Tele#:_____Emergency Tele#:_____
Name of Licensed Prescriber:_____
Prescriber's Business Tele#:_____Emergency Tele#:_____
Food/Drug Allergies:_____
Diagnosis:_____
(If not a violation of confidentiality)
Name of Medication:_____Date Ordered:_____
Duration of Order:_____Dosage:_____Frequency:_____
Route of Administration:_____Expiration Date of Medications Received:_____
Specific Directions, e.g., times to be given:_____
Possible Side Effects, Adverse Reactions:_____
Quantity of Medication Received by School and Date:_____
Required Storage Conditions:_____
Delegated to (if applicable):_____
Back-up Plans (if delegatee unavailable):_____
Plan for Field Trips:_____
Plans for teaching self administration, if applicable:_____
Other persons to be notified of medication administration (with parental permission)_____
_____
Other medications being taken by the student (if not in violation of confidentiality):_____
_____
Location where medication administration will occur:_____Health Room Other (specify):__

_____

Plan for monitoring medication, if needed:_____

_____ _____
(School Nurse Signature) (Date)

_____ _____
(Parent/Guardian Signature) (Date)

_____ _____
(Student's Signature, if appropriate) (Date)

(Medication order and parent/guardian authorization may be attached to this form.)

Form A4