Westfield Public Schools
Parental Consent and Medication Order Form

AUTHORIZATION FOR MEDICATION TO BE ADMINISTERED DURING SCHOOL HOURS

Student's Name _____ Date of Birth _____ Sex ___ Allergies _____

School _____ Grade _____ Teacher _____

Name of Parent/Guardian _____

My son/daughter is currently taking the following medications (include all medications even those given during school hours) 1._____ 2._____ 3._____ 4. _____

Can student medicate self if determined to be appropriate by nurse? _____ yes _____ no

I request that my son/daughter be given the medication(s) described below by the school nurse as authorized by myself and my prescribed provider below.
(Please note: I understand that I may retrieve the medicine from school at any time and the medicine will be destroyed if it's not picked up within one week following termination of the order or one week beyond the close of school.)

_____ _____ _____ _____
Signature Parent/Guardian Home phone Work phone Cell phone

_____ _____
Relationship to Student Date

Name and phone number of another person to be notified in case of emergency if parent/guardian is unavailable
_____

The following to be completed by the Physician or other Licensed Provider as authorized by Chapter 94C:
(Whenever possible, medications should be scheduled other than during school hours).

Diagnosis for medication given _____

Name of medication _____ Route _____ Dosage _____ Time _____

Can student medicate self if determined to be appropriate by nurse? _____ yes _____ no

List significant side effects _____

Date to start _____ Date to discontinue _____

Other information _____

Printed name of Licensed Provider _____ **Date** _____

Signature of Licensed Provider _____

Office phone number _____ **Other emergency phone** _____

School Nurse's Signature _____ **Date** _____