Athol-Royalston Regional School District

A Message to Parents, and Guardians Concerning Medication at School

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 requires that the following forms must be on file in your child's health record before we begin to give *any* medicine at school, both over the counter and prescription medication.

1. Signed consent by the parent or guardian to give the medicine. Please complete the attached 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, dentist, etc.) for completion and return 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 labeled 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 to give the medicine as soon as possible. Thank you for your help.

Sincerely yours,

Sally Quinton, R.N., School Nurse
Athol-Royalston Middle School

Phone - 978-249-2802
Fax - 978-249-7206

Attachments: Medication Order Form
Parent/Guardian Consent Form
Field Trip Form

MEDICATION ORDER FORM

(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 Number _____

Emergency Telephone Number _____

Medication _____

Route of administration _____ Dosage _____

Frequency _____ Time(s) of Administration _____

(Please note: Whenever possible, medication should be scheduled at times other than school hours)

Specific directions or information for administration: _____

_____

Date of Order _____ Discontinuation Date _____

Diagnosis* _____

Any other medical condition(s)* _____

Optional Information

1. Special side effects, contraindications, or possible adverse reactions to be observed:

   _____

   _____

2. Other medications being taken by the student: _____

   _____

3. The date of the next scheduled visit or when advised to return to prescriber: _____

4. Consent for self-administration (provided school nurse determines it is safe and appropriate)

   Yes _____ No _____

_____
Signature of Licensed Prescriber

Date: _____

*If not in violation of confidentiality

PARENT/GUARDIAN CONSENT
FOR MEDICATION ADMINISTRATION

General Information

Name of Student_____ Date of Birth_____

School _____ Grade _____

Name of Parent/Guardian _____

Address _____

Home number _____ Work number _____

Other person(s) to be notified in case of medication emergency if parent/guardian is unavailable:

Name & Relationship: _____ Telephone # _____

Name & Relationship: _____ Telephone # _____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality: 1. _____ 2. _____

3. _____ 4. _____ 5. _____

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

Student's regular health provider: _____
Licensed Prescriber

****

Consent

1. I give permission to have the school nurse or school personnel designated by the school nurse to give the following medication _____ prescribed by: (Name of Medicine)

_____ to _____
Licensed Prescriber Student's Name

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 medication administration, e.g., adverse side effects, as he/she determines necessary for my son's/daughter's health and safety.

   Yes _____ No _____ Any restrictions on release _____

   (Please note: I understand that I may retrieve the medication from the school at any time and that the medication 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 Parent/Guardian _____

Relationship to Student _____ Date: _____

Athol-Royalston Regional School District

DELEGATION OF PRESCRIPTION MEDICATIONS FOR FIELD TRIPS AND SHORT TERM SPECIAL SCHOOL EVENTS

The Athol Royalston Regional School District is registered with the Massachusetts Department of Public Health for delegation of prescription medication for field trips and short-term events only, under regulations 105 CMR 210.000.

I_____, the parent/guardian for _____,

hereby consent to allow Athol Royalston Regional School Staff, to administer the prescription medication, which I have given authorization for the above student to receive in school, on field trips and short term events. I understand that the School Nurse will instruct the ARRSD Staff in proper administration of the prescription medication prior to any field trip or event.

Signature Parent/Guardian _____

Relationship to Student _____Date _____