Saint Michael School
80 Maple Avenue
North Andover, MA 01845

Phone (978) 686-1862
Fax (978) 688-5144
st-michael@comcast.net
www.saintmichael.com

Consent for Medication Administration & Management Plan in School

Name of Student_____DOB_____Grade/Classroom_____
Address_____City_____
Parent/Guardian Name_____Emergency Phone #_____

- **Medication must be supplied in the original prescription bottle/box.** Ask your pharmacist for a duplicate bottle so that you may have one for home and one for school.
- **Parent/guardian needs to deliver the medication to the Health Office.** Medications should not be sent to school with the child.

Physician or Health Care Provider Order and Plan
I, the undersigned licensed provider, request that the school nurse or other designated person administer the medication I have prescribes as noted below.
Diagnosis_____Food/Drug Allergies_____
Medication_____Start Date_____End Date_____
Dosage_____Route_____Frequency_____Time in School_____
Possible side effects_____
Comments/other conditions to note:_____
Name of Licensed Prescriber_____Phone_____
Signature_____Date_____

Parental of Guardian Consent and Plan
Please initial or the answer to the following questions: I, the undersigned parent or guardian,

1. Give permission to the school nurse/designated personnel to administer the prescribed medication. ___Yes ___No.
2. Giver permission to the school nurse to share with appropriate school personnel information relative to the prescribed medication as deemed necessary for my son/daughter's health and safety. ___Yes ___No.
3. You may retrieve the medicine from the school at any time and that the medicine with will be discarded if it is not picked up within one week following termination of the order or on the last day of school. ___Yes ___No.

Parent/Guardian Signature_____Date_____

- Please note; all medication ordered must be reviewed and renewed on an annual basis.

Medication name/dose:_____

Date							
Quantity							
Received by							
Delivered by							