WORCESTER PUBLIC SCHOOLS

DEPARTMENT OF NURSING

MEDICATION OR TREATMENT IN SCHOOL PROTOCOL

Dear Parent/Guardian,

We would like to inform you of the protocol that is in place to ensure the health and safety of children during the school day.

Our school system requires that the following forms be on file, before we can give any medication or treatment at school:

1. Signed consent by the parent/guardian to give the medication. Please complete the enclosed consent form and give it to your school nurse. A signed consent is required for each medication or treatment.

2. Signed medication order from your child's health care provider. This order must be completed annually or as indicated by the provider. A signed order is required for each medication or treatment.

Medications should be delivered to the school nurse in a pharmacy or manufacturer-labeled container by you or another responsible adult. 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 medication to be given, during the school day, please act quickly to follow this protocol so that we may begin to give the medication as soon as possible. Thank you for your cooperation.

Sincerely yours,

____

School Nurse

Telephone: (508) 799-
FAX : (508) 799-

Medication Protocol Parent Letter Rev. 11/14/14

** **Attachment: PCP and parent/guardian Medication Administration Order and Consent Form**

WORCESTER PUBLIC SCHOOLS
DEPARTMENT OF NURSING
MEDICATION ADMINISTRATION ORDER & CONSENT
(all prescription & non-prescription medication)

School Year: 2015-2016

LICENSED PRESCRIBER

Student:____________________________________Date of Birth:_____________Grade:____________

Medication:___________________________________Dosage:________________ Route:___________

Frequency:_________________Time(s) of Administration in school:______________________________

Specific directions or information for administration:_______________________________________

Side Effects:____

Date of Order:__________________________Discontinuation Date:___________________________

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

Consent for self-administration (provided the school nurse determines it is safe and appropriate): Yes_____ No______

Diagnosis:___________________________ Other medical condition(s):___________________________

_____________________________________ ____

Printed Name of Prescriber (legibly) Signature of Prescriber

PARENT/GUARDIAN

My son/daughter has the following food or drug allergies:____

I consent to have the School Nurse administer the medication prescribed by the above licensed prescriber.
____Yes____No

I give permission for my son/daughter to self-administer medication, if the School Nurse determines it is safe and appropriate.
____Yes____No

I give permission to the School Nurse to share information relevant to the prescribed medication as he/she determines appropriate.
____Yes____No

I have read the following requirements for medication administration by the School Nurse:
Medication must be in the original prescription bottle and properly labeled.
Students under the age of 18 are not allowed to carry/transport any medication including Tylenol to and from school.
Parent/Guardian must bring in the medication and pick it up at the end of the school year.
State law mandates any medication not picked up must be destroyed.

Medication orders are in effect for the present school year/summer school program only.

Parent/Guardian Signature__________________________________Date______________________