ANDOVER PUBLIC SCHOOLS
DEPARTMENT OF HEALTH SERVICES

CONSENT FOR MEDICATION ADMINISTRATION

Name of Student_____DOB_____Grade_____School AHS_____

Address_____Tel. #_____

MEDICATION ORDER: (to be completed by a licensed prescriber)

Diagnosis _____Other Medical Conditions_____

Medication_____Dosage_____Route_____Frequency_____

Duration_____Side effects_____

Special Instructions_____Consent for self-administration_____

Signature of Licensed Prescriber_____Date_____

Name of Licensed Prescriber (please print)_____Tel.#_____

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PARENT / GUARDIAN PERMISSION:

_____I request that the school nurse, or school personnel designated by the school nurse, administer this medication to my child.

_____I give permission for my child to self-administer this medication if the school nurse determines it is safe and appropriate.

_____I give permission for the school nurse to share information relative to this prescribed medication with appropriate school personnel if it is necessary for my child's health and safety.

This student has the following allergies_____

This student is currently taking these other medications (including those not given at school)_____

_____

Parent / Guardian Signature_____Date_____

Student Signature (18 yrs. old +)_____Date_____

Home Tel. #_____Work Tel. #_____Cell Tel. #_____

Other person to call in emergency if parent is not available_____Tel. #_____

(Revised 04/2019)

AHS Clinic: Phone 978-247-5502/ Fax 978-247-5771