Swansea School Health Department
Swansea, Ma

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 district requires that the following forms must be on file in your child's health record before we begin to give any medicine at school:

1. Signed consent form by the parent or guardian to give the medication. Please complete the enclosed consent form and return it to the school nurse.
2. Signed medication order form. The written medication order form should be taken to your child's licensed prescriber (your child's physician, nurse practitioner, etc.) for completion and returned to the school nurse. **This order must be renewed as needed and at the beginning of each academic year.**

Please note the following:
Medicines should be delivered to the school in a pharmacy or manufacture labeled container by you or a responsible adult whom you designate. The medication should be in an unopened originally sealed container each time you bring new medicine or a refilled amount of medicine to the nurse. We will not transfer medication from one opened bottle to another at school.

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.

Any medications not picked up at the end of the school year will be discarded.

Thanking you in advance for your cooperation.

Sincerely yours,

School Nurse

Attachments: Written Parent/Guardian Consent Form
Medication Order Form

MEDICATION ORDER
(To be completed by a Licensed Prescriber: Physician, Nurse Practitioner or others authorized by Chapter 94C)

Name of Students_____ Date of Birth_____

Address_____ Grade_____
Street City/Town
Name of Licensed Prescriber_____ Title_____

Business Telephone Num. _____ Emergency Telephone Num. _____
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 medication 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 the school nurse determines it is safe and appropriate). Yes _____ No _____

5. Consent to carry inhaler with them at all times, if Physician deems necessary.
Yes _____ No _____

Signature of Licensed Prescriber_____

* If not in violation of confidentiality

Revised Dec 2012, June 2013, June 2014

SWANSEA SCHOOL HEALTH DEPARTMENT
PARENT/GUARDIAN CONSENT FOR MEDICATION ADMINISTRATION

General Information

NAME OF STUDENT:_____SCHOOL:_____GRADE:_____

DATE OF BIRTH:_____ SEX:_____

NAME OF PARENT/GUARDIAN:_____
(Please print)
ADDRESS:_____

TEL. NUMBER (HOME) :_____TEL. NUMBER(WORK):_____

TEL. NUMBER (Where parent/Guardian can be reached in case of emergency):_____
Other Persons, if any, to be notified in case of emergency if parent/guardian is unavailable:
Name:_____Tel. Number:_____
Relationship_____

My son/daughter is currently receiving the following medications (to be completed if not in violation of confidentiality): (Please list all medicines the child is receiving, including those given during the school day.)

1._____ 2._____ 3._____ 4._____

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

CONSENT

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

prescribed by_____ to _____
(Licensed Prescriber) (Name of Student)

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 either appropriate school personnel information relative to the prescribed medicine administration, e.g., adverse side effects, as she/he determines necessary for my son's/daughter's health and safety.

Yes _____ No _____Any restrictions on release _____

4. By signing this form I also give permission for this medication to be administered as needed by my child's teacher on any field trips that occur during the school year.

(Please note: I understand that I may retrieve the medicine from the school at any time. When the prescription is discontinued, all remaining medication will be discarded after 5 school days.)

SIGNATURE OF PARENT/GAURDIAN _____

RELATIONSHIP TO STUDENT _____DATE_____

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