Granby Public Schools

Medication Order/ Parent Consent/Medication Administration Plan

West Street School Fax 467-7163; East Meadow Fax 467-9182; Jr/Sr High School Fax 467-3909

Name of Student: ______________________________ DOB: ____________Grade:__________

Medication: ___________________________ Dose: _________________ Route: ___________

Time Given at School: ___________________ Start Date: __________ End Date: ___________

Diagnosis: _______________________ Allergies: ______________________________________

Possible Side Effects, Adverse Reactions: ____

Other Medications Taken By Student: ____

Name of Prescriber (Please print): ____________________________ Phone:_______________

***Prescribing Provider Signature:* ___________________________________ *Date:* __________**

Parent/Guardian Consent

- I give permission for the school nurse to share with appropriate school staff, after school activities coordinator, Jr/Sr high school athletic director, and local emergency medical services information relative to the prescribed medication. Yes___ No___
- I give designated school personnel (as deemed by the school nurse and parent) permission to administer this medication on a field trip during this school year (not applicable for all medications). (This includes classroom teachers). Yes___ No___
- I give permission for this student to self-administer medication if the school nurse determines it safe and appropriate. Yes___ No___
- I give permission for the school nurse to share information with the prescriber about my child and this medication. Yes___ No___

Parent/Guardian Signature:_______________________________________ Date: __________

Emergency Phones: ____

Emergency Contacts: ____

Emergency Contacts #s: ____

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******************* ***TO BE FILLED OUT BY THE SCHOOL RN*****************

•Plan for field trips/athletics/clubs/short-term events: ___________________________________
(RN needed/Medication Delegation/Self-administration)

•Med Delegated to: ____
(Name of two staff members)

•Is self-administration appropriate: Yes/No If yes, process for teaching medication self-administration:____
____

•Location where medication administration will occur: _________________________________
(Health Clinic/Other)

•Med stored: ____
(Clinic/With Student/With staff on field trips)

•Plan for monitoring medication, if needed: ____
____
____

•Staff trained in reporting & documenting med errors: Yes/No

•In event of an emergency: ____
____
____

School Nurse Signature: ______________________________________ **Date:** ______________

Please note: The School Nurse at any time has the discretion to deem a student unable to self-administer their own medication. The School Nurse at any time may also use their own discretion to deem a staff member unable to be delegated to for medication administration.