NEEDHAM PUBLIC SCHOOLS
Medication Administration Plan

Name of student _____ Date of Birth _____ Parent/guardian name _____

School _____ Grade _____ Home telephone _____

Name of licensed prescriber _____ Business telephone _____

Business telephone _____ Emergency telephone _____

Emergency telephone _____ Cell phone number _____

Food/Drug Allergies _____ **Diagnoses**:_____
(if not in violation of confidentiality)

Name of Medication: _____ **Date Ordered** _____ **Duration of Order** _____

Dosage _____ **Frequency** _____ **Route of Administration** _____ **Expiration Date of Medication Received** _____

Specific Directions, e.g., times to be given: _____

Possible Side Effects, Adverse Reactions:_____

Quantity of Medications Received by School and Date: _____

Required Storage Conditions: _____

Delegated to (if applicable): _____ Back-up Plans (if delegatee unavailable):_____

Plan for Field Trips: _____

Plans for teaching self-administration, if applicable: _____

Other persons to be notified of medication administration (with parental permission): _____

Other medications being taken by the student (if not in violation of confidentiality): _____

Location where medication administration will occur: Health Room _____ Other (specify) _____

Plan for monitoring medication, if needed: _____

School Nurse Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Student's Signature, if appropriate _____ Date _____

(Medication order and parent/guardian authorization may be attached to this form.)
MDPH 1/95