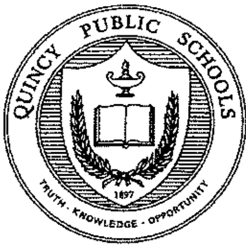

QUINCY PUBLIC SCHOOLS ______________________________

HEALTH SERVICES MEDICATION ORDER

Name of Student ____ DOB ______________

Address ____ Grade ______________

Name of Parent/Guardian ____

Telephone (H)________________ (W) ________________ (Cell) ________________

My child is currently receiving the following medication:

____

My child has the following food or drug allergies:

____

I consent to have the school nurse administer the medication as prescribed. Yes ______ No ______

I give permission for my child to carry their Inhaler or EpiPen, if the school nurse determines it is safe and appropriate. I understand it is my responsibility to provide the school nurse with backup medication. Yes ______ No ______

I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medication administration if she/he determines necessary for my child's health and safety. Yes ______ No ______

Signature of parent/guardian ________________________________ Date ______________

To be completed by M.D.

Name of Licensed Prescriber ____________________________ Telephone ______________

Address ________________________________ City/Town ______________________

Diagnosis ____

Medication ____

Dosage ________________________ **Route of Administration** ______________________

Frequency ________________________ **Time of Administration** ______________________

Possible adverse effects ____

Date of Order ____________________ **Discontinuation Date** ______________________

Signature of Licensed Prescriber ____

The Quincy Public Schools does not discriminate on the basis of race, color, sex, sexual orientation, religion, national origin, or handicap, in its educational activities or employment practices.