



Amesbury Public Schools

Cashman Elementary School
193 Lions Mouth Rd
Amesbury, MA 01913
Fax: 978-388-4479
Phone: 978-388-4407

MEDICATION ADMINISTRATION FORM

In order to administer a medication to your child, this information must be completed and signed by the appropriate personnel and returned to the school nurse.

Student Name _____ Date of Birth _____ Grade/Team/HR _____

Parent/Guardian Name(s) _____ Home Phone _____ Work Phone _____

Name of Licensed Prescriber _____ Office Phone _____

In case of emergency when parent cannot be reached call _____
Home Phone _____ Work Phone _____

Diagnosis _____ Food/Drug Other Allergies (reaction) _____

Drug Name _____ Dosage _____ Frequency _____ Time _____ Location _____

Specific directions (i.e. with food, on empty stomach etc.) _____

Potential side effects _____

Other prescription medications by student _____

All prescription medications must be stored in the prescription bottle. Other special storage conditions _____

I understand I may retrieve the medication from the school at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order or one week beyond the close of school.

Permissions:

I consent to have the school nurse or school personnel designated by the school nurse, to administer the above medication(s).

I give permission for the school nurse to share information relevant to the prescribed medication as she/he determines appropriate for my child's health and safety.

Medication should be sent and administered on field trips. YES NO

I give permission for my son/daughter to self-administer if the nurse deems appropriate. YES NO

Parent Signature _____ Date _____

Physician Signature _____ Date _____

School Nurse Signature _____ Date _____

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