GREATER NEW BEDFORD REGIONAL VOCATIONAL TECHNICAL HIGH SCHOOL

1121 Ashley Boulevard, New Bedford, MA 02745-2496
Tel. 508-998-3321 Fax 508-995-7268 www.gnbvt.edu

Preparation • Passion • Perseverance

Dear Parent/Guardian,

In order to provide medication to your child during the school day we ***require*** the attached forms to be completed (Physician Medication Order & Parent/Guardian Authorization).

MEDICATION WILL NOT BE ACCEPTED OR ADMINISTERED WITHOUT A LICENSED PRESCRIBER'S WRITTEN ORDER AND PARENTAL CONSENT FORM ON FILE IN THE NURSE'S OFFICE

Please return completed forms along with prescribed medication to the nurse's office. Please also review the attached ***Medication Administration Procedure***. Feel free to call the nurse's office at ext 204/205 with any questions. Our direct, confidential fax number is 508-9984647.

Thank you in advance for your time,

School Nurses

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MEDICATION ADMINISTRATION PROCEDURE

Massachusetts State Law prohibits the administration of medication in school without a written order from a licensed prescriber and a signed parent/guardian consent form.

We encourage families to administer medications at home whenever possible.

If it is absolutely necessary for your son/daughter to take medication (prescription or over the counter) during the school day, a written medication order from a licensed prescriber and a completed parental consent form must be on file in the nurse's office. Forms are available at the nurse's office.

All **PRESCRIPTION** medication must be delivered to the nurse's office in the original pharmacy labeled container. ***CONTROLLED MEDICATIONS MUST BE DELIVERED BY AN ADULT.***

OVER THE COUNTER medication may be delivered to the nurse's office by a student in the original, sealed container.

THE STUDENT IS RESPONSIBLE FOR REPORTING TO THE NURSE'S OFFICE AT THE DESIGNATED TIME TO TAKE HIS/HER MEDICATION.

All medication orders must be renewed each school year.

Narcotic medications are not allowed to be taken during school hours, nor should a student be under the influence of a narcotic while in school. Students requiring narcotics should remain at home.

All medication must be picked up on or before the last day of each school year. All medication not picked up will be destroyed.

ALL MEDICATION MUST BE KEPT IN THE NURSE'S OFFICE UNLESS IT IS DETERMINED BY THE SCHOOL NURSE THAT IT IS SAFE AND IN THE BEST INTEREST OF THE STUDENT TO CARRY THE MEDICATION ON HIS/HER PERSON FOR THE PURPOSE OF SELF ADMINISTRATION.

This medication procedure will be strictly enforced to ensure the safety and well being of all students.

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Nurse's Office | 508-998-3321 ext. 204/205 | FAX 508-998-4647

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Medication Order

(To Be Completed By A Licensed Prescriber – Physician, Nurse Practitioner, or Others Authorized by Chapter 94)

Student's Name:	DOB:	Grade:	
Address:	City:	State:	Zip:
Name/Title of Licensed Prescriber:	Business Phone:	Emergency Phone:	
Medication:	Dosage:		
Route of Administration:	Frequency:	Time(s) of Administration:	

Please Note: Whenever possible, medications should be scheduled at times other than school hours. Over-the-Counter medications will require a written order to be administered in school.

Special Directions/Information for Administration:

Date of Order:	Discontinue Order:

Diagnosis (If not in violation of confidentiality):

Any other Medical Condition(s):

Additional Information:

1. Special side effects, contra-indications, or possible adverse reactions to be observed:

2. Other Medications being taken by the student:

3. The date of the next scheduled visit or when advised to return to the prescriber:

Consent for self-administration provided the school nurse determines it is safe and appropriate: ☐ YES ☐ NO

Signature of Licensed Prescriber:	Date:

Comments:

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Parent/Guardian Authorization for Dispensing Medication

(To Be Completed By Parent/Guardian)

Student's Name:	DOB:	Gender:

Address:	City:	State:	Zip:

Parent/Guardian Name(s):	Home Phone:	Cell Phone:	Work Phone:

Emergency Contact (If Parent/Guardian unavailable):	Telephone:	Relationship:

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

My child is known to have the following allergies:

I give permission to have the school nurse/trained personnel give the following medications:

Prescribed by:	To (Child's Name):

I give permission for my child to self-administer the medication if the school nurse determines that it is safe and appropriate.
YES ☐ NO ☐

My child has my permission to self-administer his/her inhaler according to the physician's order/instructions on the day of his/her field trip.
YES ☐ NO ☐

My child has my permission to self-administer his/her daily medication according to the physician's order/instructions on the day of his/her field trip.
YES ☐ NO ☐

I give permission for the school nurse to train unlicensed school personnel to administer epinephrine (by auto-injector) to my child with a diagnosed life-threatening allergic reaction condition when the school nurse (RN) is not immediately available or on field trips. YES ☐ NO ☐

I understand that I may retrieve the medication from the school at any time and that the medication will be destroyed if it is not picked up within one week following the expiration of the order or by the last day of the school year. I also understand that the school nurse may share, with appropriate school personnel, information relative to the prescribed medication, e.g., adverse effects, as he/she determines necessary for my child's health and safety. (if you object to this, please contact the school nurse).

Signature of Parent/Guardian:	Date:	Relationship to Student: