Parent/Guardian Medication Administration Plan
Medfield Public Schools

Prescription and non-prescription medications, not covered by standing orders from the MPS school physician, for a student during regular school activities ***require a medication order AND Medication Administration Plan***, developed by the school nurse and parent/guardian

This form is valid for school year 20___- 20___

Name of Student_____D.O.B._____Grade_____

Diagnosis:

_____

Known Medication Allergies:

_____

Name of Medication(s) to be administered at school:

_____

_____

_____

Field Trip Plan:
❑Above medication(s) do not need to be administered on field trips
❑Please plan to administer listed medication(s) on field trips

_____

_____

Nurses do **not** routinely go on field trips. The department of Public Health regulations allows us to delegate responsibility for select medications and the administration of epinephrine via a single dose auto injector or nasal administration in an emergency situation to non-medical, trained school staff. MPS staff are trained in Epinephrine Administration on an annual basis. Medications such as Benadryl or Zyrtec that are to be given on an "as needed" basis will **not** be going on any field trips unless a nurse is attending. Epinephrine will be administered for a life threatening allergic reaction on all field trips.

Students at the elementary school level do not usually self-carry their own mediation on a field trip: teachers or a trained adult carry the medication. A student may self administer if the healthcare provider and school nurse have signed off that the student is developmentally able to self administer the medication if needed. Parents of students with medical needs are always welcome to attend field trips.

***I give permission for the above medication(s) to be administered as prescribed to my student. I understand no more than a 30 day supply of medication(s) should be delivered to the school, and medication(s) will be destroyed if not picked-up by the expiration date or the last day of school.**

Parent/Guardian Signature _____ Date_____

Approved By School Nurse_____ Date_____

(Medication order(s) MUST be included with this form

ONLY COMPLETE THIS SECTION FOR SELF-CARRY/ADMINISTRATION
Typically Secondary Level Only

Plan for teaching self-carry/administration (as appropriate for: prescription inhalers, epinephrine, insulin delivery systems, etc) will be allowed only when the criteria of the Self Administration Medication Plan have been met and parent/guardian, student AND school nurse enter into agreement.

***I (Parent/Guardian) give permission for my student to self-carry/administer the listed medication(s).**

_____

_____

Parent/Guardian Signature _____ Date_____

***I (Student) know when and how to take the above list medication(s), and will inform the school nurse of any issues.**

Student Signature_____Date_____

School Nurse Must Complete Below

Storage Location of medication (check all that apply): ❑ Health Office ❑ Self-carry

Plan for Field Trip: ❑ Send on Field Trip/administer by designated school staff ❑ Self-carry
❑ Other:_____

Approved by School Nurse _____Date_____