MASCONOMET REGIONAL SCHOOL DISTRICT
Medication Administration Plan

Name of student_____ Date of Birth_____ Grade_____

Parent/guardian name_____Home telephone_____

Business telephone_____Cell Phone_____

Food/drug Allergies_____

Diagnoses:_____
(if not a violation of confidentiality)

Name of Medication:_____Name of licensed prescriber_____

Date Ordered_____ Duration of Order_____Dosage_____

Frequency_____ Route of Administration_____Expiration Date of Medications _____

Quantity of Medication Received by School and Date:_____

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

_____

Possible Side Effects, Adverse Reactions:_____

_____

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

Plan for Field Trips:_____Plan for Early Release Days_____

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_____