MANSFIELD PUBLIC SCHOOLS HEALTH SERVICES
MEDICATION ADMINISTRATION PLAN/CONSENT

(All medication must be delivered to school in its original container with the pharmacy label attached. All medications including over-the-counter, must be accompanied by a licensed prescriber's order)

Students Name _____**D.O.B**._____

Physician _____ Physicians Phone _____

Allergies _____

Diagnosis related to this prescription _____

Any other diagnosis _____

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(*To be completed by Physician)*

Name of medication _____

Dose _____ **Frequency** _____ **Route** _____Time of school Dose(s) _____

Special Instructions _____

Other medications being taken by the student _____

Physician Signature_____**Date**_____

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(*To be completed by parent/guardian)*

Field Trip Plan: In case of school field trips, this medication will be: **(initial one of the options below)**

- Given by delegated trained school personnel (such as a teacher) _____
- Self Administered by the student _____ with nurse approval.

*If self administered parent will send medication with student**.**

I give the School Nurse permission to administer this medication to my child.
The School Nurse may share information about my child's medication with appropriate staff.
The School Nurse may consult my child's physician if she has any questions or concerns about administering this medication to my child.
I understand that it is my responsibility to pick-up this medication when it is no longer needed at school and that this medication will be destroyed or properly disposed of after its expiration date or on the last day of the school year.

Parent Signature _____ **Date** _____