South Shore Educational Collaborative

75 Abington Street
Hingham, MA 02043
www.ssec.org

Phone: 781-749-7518
Fax: 781-740-0784
E-mail: info@ssec.org

Medication Administration Plan (Page 1 of 2)

Student Name: _____(Circle One) Male Female Non-Binary

Date of Birth: _____ Grade: _____ Date of Consent: _____

My child is known to have the following allergies:_____

Medical Diagnosis (if not in violation of confidentiality):_____

1. I request and give permission to the school nurse to give child:
Medication: _____ _____ Dosage:_____ Route:_____

Time of Day:_____Prescribed by_____

2. I give permission for my son/daughter to self-administer (carry the medication and administer by him/her-self during class/field trip) NOT in the presence of the school nurse. Note: Self administration is reserved for students who have an Epi-pen, enzyme supplement, inhaler or diabetic supplies as per the regulations of the Commonwealth of MA. (circle one)

Not Applicable Yes No

If I give my permission, I understand the school nurse and I must be in agreement that my student demonstrates the ability and understands all aspects of administration of this medication as directed. I also agree to provide a back-up supply for the nurse to keep in the health office in the event my student does not have his/her prescribed medication/supplies in his/her possession when needed.

3. I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medicine administration as s/he determines necessary for my child's health and safety.

(circle one) Yes No

4. I understand that in the event of a field trip, this medication administration plan may need to be adjusted and I will do the following:
Call the school nurse prior to the field trip to discuss the plan for administering this medication
This medication may be withheld (not given) on the day of the field trip.
Not Applicable -Self administration selected in #2 above

5. I understand that I may retrieve the medicine from the school at any time, and that the medicine will be destroyed if it is not picked up within one week following the termination of the order or the last day of school.

Parent/GuardianName(Print)_____

Parent/Guardian Signature:_____ Date:_____

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Medication Administration Plan (Page 2 of 2)

Student Name:_____ (Circle One) Male Female Non-Binary

Medication:_____ Duration of Medication Order:_____

Date Ordered:_____ Expiration Date of Medication:_____

Time(s) to be Given:_____ Quantity Received:_____

Contraindications/Side Effects:_____

Onset/Peak/Duration: O:_____P:_____ D:_____

Refrigeration: (Circle One) Yes No

IHCP Indicated:(Circle One) Yes No

MD order received: (Circle One) Yes No

Entered into Health Office Computerized Database:_____

Medication Administration record completed and placed in medication book:_____

School Nurse Signature: _____Date:_____

Medication may be given up to 1 hour before or after scheduled time; or at an alternate time if school schedule or activities change.

03/29/21 PA