FRANKLIN COUNTY TECHNICAL SCHOOL
82 Industrial Boulevard
Turners Falls, MA 01376
TEL: 413-863-9561 FAX: 413-863-2816
www.fcts.org

Medication Order and Parent/Guardian Consent

Name of Student:_____ Date of Birth: _____Grade_____

Name of Parent/Guardian:_____

Student Address:_____

Home Phone:_____Work Phone:_____Cell Phone: _____

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Name of Prescriber: _____Phone:_____

Address:_____

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Medication:_____Dose:_____Route:_____

Time given at school:_____Start date:_____ End date:_____

Diagnosis:_____Allergies:_____

Other medications taken by student*:_____

- I give permission to the nurse at school to administer this student the medication on this order.
- I give permission for the nurse at school to share with appropriate school staff information relative to the prescribed medication administration as deemed necessary Yes_____No_____
- I give permission for this student to self-administer medication if the nurse at school determines it is safe and appropriate (inhalers, Epipen, insulin only). Yes_____No_____
- I give designated school personnel permission to administer this medication on a field trip during this school year (scheduled medications, inhalers and EpiPen only). Yes_____ No_____
- I give permission for the nurse at school to share information with the prescriber about my child and this medication. Yes__ No___

Parent/Guardian
Signature:_____Date: _____

Prescribing Provider
Signature:_____Date:_____

* If not in violation of confidentiality