



FRANKLIN PUBLIC SCHOOLS – MEDICATION ORDER FORM

School Name: _____

Date: _____

School Fax #'s:

ECDC: 508-541-8254

Jefferson: 508-541-2124

Keller: 508-541-2109

Kennedy: 508-553-0892

Oak Street: 508-541-8047

Parmenter: 508-553-0894

Horace Mann: 508-541-7071

Remington: 508-541-2101

Annie Sullivan: 508-541-2109

High School: 508-613-1510

To be Completed by Licensed Prescriber (One form per medication)

Student Name _____ Age _____ Grade _____

Diagnosis _____

Medication _____ Dosage _____

Route _____ Frequency _____

Specific Directions _____

Date of Order _____ Discontinue Date _____

Special side effects, contraindications or possible adverse reactions to observed for:

Consent for self-administration (provided the school nurse determines it safe and appropriate)

Yes _____ No _____

Other medical conditions _____ Allergies _____

Signature of Provider

Date

Print Name of Provider

Telephone Number

Written Parent/Guardian Consent

Name of Parent/Guardian _____ Tel. Number _____

- I give my permission to have the school nurse, or designated personnel, give the following medication _____ to my child.
- I give permission for my child to self-administer medication if the school nurse determines it is appropriate. Yes _____ No _____
- I give the school nurse permission to share with appropriate school personnel, information relative to the prescribed medication. Yes _____ No _____

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

Parent/Guardian Signature

Date