Tewksbury Public Schools
School Health Services
Medication Administration Plan (to be completed by a licensed prescriber)

Name of Student_____Date of Birth _____

Address_____ Grade _____
(street) (city/town)

Name of License Prescriber_____Title_____

Business Phone_____ Emergency Phone_____

Medication_____

Route of administration_____ Dosage_____

Frequency_____Time(s)Administration_____

Plan for monitoring medication if needed:_____
(Please note: Whenever possible, medication should be scheduled at times other than school hours).

Specific storage directions or information for administration:_____

Date of Order_____ Discontinuation Date_____

Diagnosis_____

Any other medical condition(s) or allergies:_____

Optional Information
1. Special side effects, contraindications, or possible adverse reactions to be observed:_____
2. Other medication being taken by the student:_____
_____
3. The date of the next scheduled visit or when advised to return to the prescriber: _____
4. Consent for self administration according to school protocol (provided the school nurse determines it is safe and appropriate). Yes_____ No_____

_____ Signature of Licensed Prescriber

MEDICATION INVENTORY

STUDENT NAME: _____ DOB:_____

MEDICATION: _____ Dosage: _____

Date: _____

Amount received: _____ Total: _____
Parent: _____ Nurse initials: _____

Notes: _____

Date: _____

Amount received: _____

Parent: _____ Nurse initials: _____

Notes: _____

Date: _____

Amount received: _____

Parent: _____ Nurse initials: _____

Notes: _____

Date: _____

Amount received: _____

Parent: _____ Nurse initials: _____

Notes: _____

Date: _____

Amount received: _____

Parent: _____ Nurse initials: _____

Notes: _____

Date: _____

Amount received: _____

Parent: _____ Nurse initials: _____

Notes: _____

Returned to parent? _____

Revised form 4/2023