FAIRHAVEN PUBLIC SCHOOLS
FAIRHAVEN, MASSACHUSETTS

MEDICATION ADMINISTRATION PLAN

Name of Student _____ Date of Birth _____
School _____ Grade _____
Name of Licensed Prescriber _____
Business Telephone Number _____
Emergency Telephone Number _____

Parent/Guardian Name _____
Home Telephone Number _____
Business Telephone Number _____
Emergency Telephone Number _____

Food/Drug Allergies _____

Diagnoses: _____
(if not a violation of confidentiality)

Name of Medication _____ Date Ordered _____ Duration of Order _____
Dosage _____ Frequency _____ Route of Administration _____ Expiration Date of Medications Received _____
Dosage Change _____ Date _____ Dosage Change _____ Date _____
Specific Directions, e.g., times to be given: _____
Possible Side Effects, Adverse Reactions: _____
Required Storage Conditions: _____
Delegated to (if applicable) _____ Back-up Plans (if delegatee unavailable): _____
Plan for Field Trips: _____
Other staff to be notified of medication administration unless parent/guardian object: _____
Other medications being taken by the student (if not in violation of confidentiality): _____
Location where medication administration will occur: _____ Health Room _____ Other (specify) _____
Plans for teaching self-administration, if applicable:

Plan for monitoring medication, if needed:

School Nurse Signature _____
Date _____

Information obtained from _____
Date _____
Student's Signature, if appropriate _____
Date _____