



**This form is only for students who require prescription medication at school:**

(Example: Inhaler, EpiPen, ADHD Medication)

# Excel Academy Medication Administration Plan

Name of student: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/guardian name: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency contact #: \_\_\_\_\_

### **Medication #1:**

Name of Medication: \_\_\_\_\_

Diagnoses (what the medication is used for): \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency (how often): \_\_\_\_\_ Route: \_\_\_\_\_

### **Medication #2:**

Name of Medication: \_\_\_\_\_

Diagnoses (what the medication is used for): \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Frequency (how often): \_\_\_\_\_ Route: \_\_\_\_\_

Approval for trained staff other than the school nurse to administer med: \_\_\_ Yes \_\_\_ No

1. **Possible Side Effects:** \_\_\_\_\_

\_\_\_\_\_

2. **Other medications being taken by the student at home:**

\_\_\_\_\_

3. **Other individuals to be notified when medication is administered:**

\_\_\_\_\_

4. **Food/drug Allergies:**

\_\_\_\_\_

<p>I will call my doctor and ask them to fax a  <b>"Medication Order"</b> to:</p>	<p>617-399-6867 (Chelsea Campus)  617-674-3429 (Greenway Campus)  617-665-6089 (East Boston Campus)  617-674-3427 (MA High School )  401-619-0010 (Rhode Island Middle School)  401-213-8551 (Rhode Island High School)</p>
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I consent to the Medication Administration Plan

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Typing name serves as a signature)

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## To Be Completed by the School Nurse Only:

- **Date Ordered:** \_\_\_\_\_ **Duration of Order:** \_\_\_\_\_
- **Expiration Date of Medications Received:** \_\_\_\_\_  
Date Medication Received: \_\_\_\_\_ Quantity of Medication Received \_\_\_\_\_
- **Storage Requirements:**  
Locked Up \_\_\_\_\_ Unlocked \_\_\_\_\_ Room Temperature \_\_\_\_\_ Refrigerated \_\_\_\_\_
- **Location where medication administration will occur:** \_\_\_\_\_ Health Room  
\_\_\_\_\_ Field Trips \_\_\_\_\_ Off campus enrichments \_\_\_\_\_ Other \_\_\_\_\_
- **Delegated to:** Administration Team, Grade Level Team Leads, Athletic Coaches  
**Back-up Plans:** Administration team, Grade Level Team Leads, Athletic Coaches
- **Plan for Field Trips:** The Administration Team or Grade Level Team Leads will carry student medications
- **Plans for teaching self administration, if applicable:**  
\_\_\_\_\_
- **Plan for monitoring the effects of medication, if needed:**  
\_\_\_\_\_

### EpiPen Only Questions:

Location of where the medication is stored: \_\_\_\_\_

Plan for Risk Reduction:

- All outside food brought into school is approved by the school nurse
- Students who eat common allergens are required to clean their desk & wash their hands after eating

School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Typing name serves as a signature)