MEDICATION PRESCRIPTION FORM

THACHER MONTESSORI SCHOOL

Our policy permits a responsible, trained student to carry and/or self-administer medication with parent request and approval and school nurse approval. Medication administered must be consistent with school policy and a medical plan must be developed with the school nurse in accordance with the Massachusetts Regulations Governing the Administration of Prescription Medication in Public and Private Schools (105 CMR 210.000).

Please note that per the MDPH, over the counter medications also require this form to be filled out by an M.D., or other licensed prescriber

To be completed by a licensed prescriber

Date: _____

Name of student: _____ Date of birth: _____

Address: _____

Medication: _____ Dosage: _____

Route of Administration: _____ Frequency: _____ Time(s): _____

Specific directions for administration: _____

Diagnosis/Reason for Medication:_____

Medication: _____ Dosage: _____

Route of Administration: _____ Frequency: _____ Time(s): _____

Specific directions for administration: _____

Diagnosis/Reason for Medication:_____

Name of Licensed Prescriber: _____

Address of Prescriber _____Prescriber phone#_____

Signature of Licensed
Prescriber_____Date_____