LL SAINTS ACADEMY
ın E. Matys, Head of School
ɹadofschool@allsaintswebster.org

ELEMENTARY CAMPUS
48 Negus Street, Webster, MA 01570
Phone: 508-943-0257 Fax: 508-461-9666
ElemOffice@allsaintswebster.org

LE SCHOOL CAMPUS
ıy Street, Webster, MA 01570
e: 508-943-2735 Fax: 508-943-6215
fice@allsaintswebster.org

ite: www.AllSaintsWebster.org

NEA S&C Accredited

Part A: To be filled out by a Licensed Prescriber:

Name of Student: _____ Date of Birth: _____

Doctor / Prescriber Name: _____

Office Location: _____

Telephone / Contact Number:_____

Name of Medication: _____

Route: _____ Dose: _____

Frequency: _____ Time: _____

Date of Order: _____ Discontinuation Date: _____

Diagnosis: _____

Any other medical conditions: _____

Additional Information:

1. Special side effects, contraindications, or possible adverse reactions to be observed: _____
   _____
2. Other medication being taken by the student: _____
   _____

Signature of Licensed Prescriber: _____

Part B: To be filled out by Parent / Guardian:

1. I give special permission for the school nurse to administer medication as per this medication order.
   YES_____ NO_____

2. I give permission for the school nurse to instruct a trained, responsible adult in administering the above mentioned medication to my child.
   YES_____ NO_____

Parent / Guardian Signature: _____