SEEKONK HIGH SCHOOL
261 Arcade Avenue
Seekonk, Ma. 02771
(508) 336-7272
FAX: (508) 336-8535

MEDICATION ADMINISTRATION PLAN

Student_____D.O.B._____

Parent/Guardian_____
Home Telephone_____Work Telephone_____
Name of Medication_____Dose_____
Route_____Time of Administration_____
Diagnoses:_____
***if not in violation of confidentiality**
Side effects/Adverse Reactions:_____
Plan for field trips:_____
Other medications being taken by student_____

Location where medication will be kept:
_____Health Room _____Main Office _____With student_____Other

In some instances, faculty may inquire about a student taking medication in school. This information is considered confidential and is shared with faculty on a "need to know basis".
_____Check here if it is NOT acceptable to discuss medication issues with faculty.
_____Check here if permission is granted to discuss pertinent medication information as needed with faculty.

If an emergency should occur and there is no licensed personnel available to administer your child's medication here at school, would you like to be called to come in to administer the medication or would you like the medication dose to be omitted.
_____Please omit the medication _____Please call me

Parent/Guardian Signature_____