WINCHESTER PUBLIC SCHOOLS
Medication Form

Student_____ Date of Birth_____

School_____ Grade _____ Team_____

Food/Drug Allergies _____

Diagnosis_____

Name and strength of Medication_____

Dosage_____ Frequency_____ Route of administration_____

Date to begin_____ Date to end_____

Special Instructions, e.g., times to be given:_____

Possible Side Effects, Adverse Reactions:

_____

Other medications taken by student at this time_____

_____

NOTE: All medications must be in the original container with physician information. No more than a 30 day supply may be accepted.
Quantity of medication received by school nurse and date:_____
Expiration date of medication received:_____

Name of licensed prescriber:_____Phone#_____

Date_____Physician Signature_____

Date_____Parent/Guardian Signature_____

School	Nurse	Telephone	Fax
WHS	Nurse Leader		
	Jennifer Markham, MSN, RN, CPNP	781-721-7020 X4011	781-721-7042
	Elizabeth Scamperle,MS,RN,ANP-BC	781-721-7020 X3	781-721-7042
McCall	Lynn Vozzella, M.Ed, BSN, RN	781-721-7026 X1119	781-721-0886
	Marie Saba, MSW,BSN, RN, LICSW	781-721-7026 X1129	781-721-0886
Ambrose	Nancy Boyle, M.Ed, BSN, RN	781-721-7012 X159	781-721-5605
Lincoln	Michelle Mercurio, MSN, RN	781-721-7017 X4	781-721-7040
Lynch	Donna Wallace, M.Ed, BSN, RN	781-721-7013 X137	781-721-4480
Muraco	Deborah Provanzano, BSN, RN	781-721-7030 X114	781-721-0244
Vinson-Owen	Clare Secatore, BSN, RN	781-721-7019 X5	781-729-2681

Medication Administration Plan

Location of where medication administration will occur: Health Office_____

or other area (specify)_____

Plan for monitoring medication effect, if applicable:_____

_____

MEDICATION DELEGATION:
Medication Administration Delegated to, if applicable:_____

Back up plans (if delegatee is unavailable):_____

Staff trained, if applicable_____ Staff signature_____

FIELD TRIPS:
Can the school nurse delegate a teacher to give this medication on a field trip?_____

Plan for Field Trips_____

Staff trained, if applicable_____ Staff signature_____

Plans for teaching self administration, if applicable:_____

_____

To be signed by the Parent/Guardian: I, the undersigned, give permission to the school nurse to administer or to supervise my child in taking the above medication.
I understand the school personnel are not responsible for any problem arising from the effects of the medication or for the omission of the medication.
I further agree to indemnify and hold harmless the Town of Winchester and its agents and servants against all claims as a result of any and all acts performed under this authority.

Parent/Guardian Name_____

Parent /Guardian Signature_____Date_____

Best phone number to reach parent/guardian_____

School Nurse Signature_____Date_____

Student's Signature, if applicable_____ Date_____