COMMUNITY CHARTER SCHOOL OF CAMBRIDGE

617 354-0047 **P**
617 354-3624 **F**
info@ccscambridge.org **E**
245 Bent Street
Cambridge, MA 02141
www.ccscambridge.org

SCHOOL-BASED MEDICATION ADMINSTRATION PLAN
(TO BE COMPLETED BY PHYSICIAN)

DATE of PLAN:

Name of Student: _____ Date of Birth: _____

Parent/Guardian Name: _____

Contact Telephone H: _____ C: _____ W: _____

Alternate Contact Name: _____ Phone: _____

Physician or Prescribing Provider: _____

Address: _____ Phone: _____

Diagnosis: _____

Name of Medication: _____ Dose: _____ Route: _____

Date Ordered: _____ Quantity: _____

Frequency and Time of Dose: _____ End Date of Medication: _____

Storage Location: _____

Self- Administered Permitted: YES / NO

Special Instructions/Plan of Administration: _____

Side Effects: _____

Follow up to Medication Administration if any: _____

Designated Administration Personnel, if any: _____

Field Trip / Off Campus Plan: _____

Signature of Physician: _____ Date: _____
Signature of Parent: _____ Date: _____
Signature of School Representative: _____ Date: _____

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SCHOOL-BASED MEDICATION ADMINISTRATION AUTHORIZATION
(TO BE COMPLETED BY PARENT)

Date: _____

Name of Student: _____

DOB: _____

Address: _____

Parent / Guardian: _____

Relationship to Student: _____

Emergency Contact: _____

H: _____

C: _____

W: _____

Secondary Emergency Contact: _____
H: _____
C: _____
W: _____

CCSC student, _____ is hereby authorized by the parent/guardian, _____, to receive the medication (s) detailed on the accompanying School-Based Medication Administration Plan.

Signed: _____
Printed Name: _____
Date: _____