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SCHOOL-BASED MEDICATION ADMINISTRATION 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:** _____

The Community Charter School of Cambridge will prepare a diverse student body grades 6-12, for postsecondary education, work, and citizenship. At CCSC, all students are known well, encouraged to meet high expectations, and linked to their community through internships and other field experiences,

CCSC can make documents available in any language upon request. • CCSC ka ba ou dokiman ekri an kryol si ou vle. • La escuela CCSC le tendra los documentos disponibles a su peticion.



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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: _____

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