

WESTWOOD-MANSFIELD PEDIATRIC ASSOCIATES, P.C.

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To be completed by Physician:

Is it necessary for the following medication to be given during school hours?

Yes: _____ No: _____

Name of Student: _____

Address: _____

School/Grade: _____

Medication: _____

Route of Admin: _____ Dosage: _____

Frequency: _____ Times: _____

Start Date: _____ Stop Date: _____

Special Instructions: _____

Possible Side Effects: _____

*Diagnosis: _____

Comments: _____

*If not in violation of confidentiality.

Physician Signature

Date

Westwood-Mansfield Pediatrics Associates, Inc.
541 High Street
Westwood, MA 02090

Telephone: (781)-326-7700
Fax: (781)-251-0910

Commonwealth of Massachusetts
Department of Early Education and Care

MEDICATION CONSENT FORM 606 CMR 7.11(2)(b)

Name of child: _____

Name of medication: _____

Please ✓ one of the following: Prescription: _____ Oral/Non-Prescription: _____

Unanticipated Non-Prescription for mild symptoms _____

Topical Non-Prescription (**applied to open wound/ broken skin**) _____

My child has previously taken this medication _____

My child has **not** previously taken this medication, but this is an emergency medication and I give permission for staff to give this medication to my child in accordance with his/her individual health care plan _____

Dosage: _____

Date(s) medication to be given: _____

Times medication to be given: _____

Reasons for medication: _____

Possible side effects: _____

Directions for storage: _____

Name and phone number of the prescribing health care practitioner:

Child's Health Care Practitioner Signature _____ **Date** _____

I, _____, (parent or guardian) gives permission
(print name)

to authorize educator(s) to administer medication to my child as indicated above.

Parent/Guardian Signature _____ **Date** _____

For topical, non-prescription **NOT** applied to open wound / broken skin (**parent signature only**)