MILFORD SCHOOL DISTRICT PARENT / PHYSICIAN PERMISSION FOR MEDICATION FORM

PHYSICIAN'S STATEMENT AND AUTHORIZATION

NAME______________________________ DOB________ SCHOOL __________ GRADE ________

Name of Medication______________________________ Dosage __________ Route ________

Time to Administer __________ **WITH** or **AFTER** meals. (Please circle)

Side Effects ______________________________ Diagnosis ________________

Name of Medication______________________________ Dosage __________ Route ________

Time to Administer __________ **WITH** or **AFTER** meals. (Please circle)

Side Effects ______________________________ Diagnosis ________________

Permission is granted for ______________________________ to possess and self-administer

Asthma inhaler __________ Epi-Pen __________ mg according to prescribed specifications.

I have instructed the child in the proper way to use his/her medication(s). If it is necessary to use this medication, he/she should immediately go to the school nurse for appropriate follow up care. (RSA 200:43)

PHYSICIAN'S NAME (PRINT) ______________________________

PHYSICIAN'S SIGNATURE ______________________________

DATE ______________ **DOCTOR'S TELEPHONE** ______________________________

PARENT OR GUARDIAN'S AUTHORIZATION

I hereby request and give my permission for a designated member of the school staff to assist my child ______________________________ in taking the above medication. I release said person from responsibility for any adverse effects from the medication or from effects when my child refuses to cooperate in taking said medication.

- No more than a 30 day supply of medication will be kept at school.
- Medications must be delivered directly to the school nurse by a parent or guardian.
- The medication must be delivered in the original prescription container from the pharmacy, or the manufacturer's container.
- Children under the age of 18 are not allowed to transport medication to and from school.
- THIS FORM MUST BE COMPLETED BEFORE THE START OF EACH SCHOOL YEAR AND IF A NEW MEDICATION IS PRESCRIBED DURING THE SCHOOL YEAR.

Parent Signature______________________________ Date ________________

I have been informed of the above information and want my child to carry and self-administer his/her own inhaler and/or Epi-Pen.

_______ I request that my child be allowed to self-administer his/her ________________ inhaler.

_______ I request that my child be allowed to self-administer his/her Epi-Pen.

Parent Signature______________________________ Date ________________