School Medication Form

Monadnock Regional School District
(603) 352-6955

PARENT MEDICATION PERMISSION School: _____

I request that my child, _____ be permitted to take the following medication, _____ while at school.

The medication will either be administered by the school nurse or other designated, trained personnel, as appropriate. The medication shall be delivered to the school nurse by a parent or other assigned adult.
Prescription medications **MUST** be in the original pharmaceutical container and properly labeled. Students may be allowed to carry their own medication when the school nurse determines it is appropriate and the student has demonstrated capability for self-administration and responsible behavior. Both physician and parent consent are required.

*** No more than a 30 school-day supply of the prescription medication for a student shall be stored at school at any given time.**

I consent to self-administration of this medication for my child. Yes ____ No ____

Name of Parent or Guardian: _____

Signature: _____

Phone Number: _____ Date: _____

PHYSICIAN MEDICATION FORM

Please accept this written order for: _____ to receive the following medication while at school sponsored activities. (Student's name)

Diagnosis: _____

Medication: _____

Dosage: _____ Route: _____

Possible Side Effects: _____

Order Effective Date: _____ Order Termination Date: _____

Is the student qualified /able to carry and self-administer this medication? Yes ____ No ____

Physician's Signature: _____

Physician's Printed Name: _____

Today's Date: _____

Office Phone #: _____

Physician's office stamp, if desired