RSU

Durham-Freeport-Pownal
Medication Request/Permission Form

No Medication **(whether over the counter or prescribed) will be administered without this information.**

Student Name:_____ DOB: _____School:_____Grade:_____

Name of Medication:_____Reason:_____

Type of Medication:

❑ Tablet/Capsule ❑ Liquid ❑ Inhaler ❑ Injection ❑ Nebulizer ❑ Other

Instructions during the School Day:

Dose:_____Time:_____Frequency_____

❑ For episodic/emergency events only:_____

Start: ❑ Date form received ❑ Other date:_____ Stop: ❑ End of school year ❒ Other date:_____

Special instructions/side effects: _____

Special storage requirements: ❑ None ❑ Refrigerate ❑ Other:_____

The administration of this medication during the school day is necessary for the student's health and attendance in school. It is recommended that the first dose of a newly prescribed medication be given at home.
This student has the knowledge and skill to carry and self-administer this medication, if allowed by school policy. ❑ Yes ❑ No

Physician's Name: _____ ***Physician's Signature:*** _____

Phone Number: _____ ***Fax:***_____

MEDICATION MUST BE BROUGHT TO SCHOOL IN THE ORIGINAL CONTAINER BY THE PARENT/GUARDIAN
(pharmacy will provide an extra labeled container if needed)

I request and give permission for the school nurse or other unlicensed trained school personnel to administer the above medication to my child. Information regarding this medication may be shared with the appropriate school personnel. **NOTE:** Any changes to the information above shall require a new Request/Permission form.

Permission to Contact Prescribing Physician : I understand and agree that if the school nurse has questions regarding the physician's order, I give my permission for the school nurse to contact my child's physician and obtain additional information about the medication, administration schedule, and the effects of the medication on my child's learning. I consent to the physician providing that information.

Medication Removal:
I understand that I must pick up any medication no longer required or remaining at the end of the school year or it will be approriately discarded.

My child may carry and self-administer this medication if allowed by school policy. ❑ Yes ❑ No

Parent or Legal Guardian's Signature:_____Date: _____

Home Phone:_____ Work: _____Cell: _____

To Be completed by School Nurse:

This student demonstrates the knowledge and skill to carry and self-administer this medication. ☐ Yes ☐ No

School Nurse Signature: _____Date: _____

Updated 10/2017 Nsg PLC