RSU No 5 Durham-Freeport-Pownal

Medication Request/Permission Form

MEDICATION MUST BE BROUGHT TO SCHOOL IN THE ORIGINAL CONTAINER BY PARENT/GUARDIAN

(pharmacy will provide an extra labeled container if needed)

No Medications **(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: ❑ **When form is received** ❑ **Other:** _____ **Stop Date:** ❑ **End of school year** ❒ **Other:** _____

Important Side Effects or Restrictions: ❑ **None** ❑ **Yes, Please describe:** _____

Special instructions: _____

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

The administration of this medication during the school day is necessary for the student's health and attendance.
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 Printed Name: _____

Physician's Signature: _____

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

I request and give permission for the school nurse or other unlicensed trained school personnel to administer the above medication to my child. The school may refuse any and all requests not in compliance with the school policy JLCD. 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 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 appropriately discarded.
My child may carry and self-administer this medication if allowed by school policy. ❑ Yes ❑ No

Parent /Legal Guardian's Signature: _____ ***Date:*** _____

Home Phone: _____ ***Work:*** _____ ***Cell:*** _____

To be completed by School Nurse

This student demonstrates the knowledge and skill to carry & self-administer this medication. ❑ Yes ❑ No
School Nurse Signature: _____ ***Date:*** _____