

STRATHAM MEMORIAL SCHOOL

Tom Fosher, Principal

39 Gifford Farm Road
Stratham, N. H. 03885
603-772-5413

Judy Lewis, R.N.

Permission form for the dispensing of medications in school

My child, _____ is required by Doctor _____, the prescribing physician, to take the following medication during school time:

Name of medication: _____

Dosage: _____

Time schedule to be observed: _____

Method of taking medication: _____

Reason for taking medication: _____

Possible adverse reactions: _____

Other medication(s) student is taking at this time: _____

In the event of a medication emergency, please list persons to be notified other than parents and physician: _____

Doctor's phone # _____ Parents' #'s _____

Other Emergency Numbers _____

Prescription medications must be accompanied by a written order from the prescribing doctor and in a medicine bottle with the prescription label. The medicine will be delivered, by the parent or guardian, to the school nurse in a pharmacy labeled container listing the student's name, the physician's name, the medicine, and the instructions for this medication.

Over the counter medication may be given, if needed, with the written request of the parent/guardian. The medication must be supplied in its original container.

We, the parents, authorize the school nurse or any other member of the staff so designated by the building principal to assist* our child in taking the above medication. Any pupil in grades Kindergarten through the twelfth grade must be assisted by such persons, and the medication, therefore, shall be in the custody of such persons. If the medication is an **emergency medication** that must be carried by the student, a written permission form must be in the nurse's office. The nurse and the school principal must give sanction for this medication to be carried by the student.

I, the parent or guardian, agree by signing this request form to the "HOLD HARMLESS" Statement that follows: I agree that I will not hold liable any member of the school staff who is directed by me to assist my child in taking the above stated medication.

* Assist means having the required medication available to the child as needed and observing the student as he/she takes or does not take his/her medication.

Parent's/Guardian Printed Name _____

Parent's/Guardian Signature _____ Date _____