

**SAU 71 LEMPSTER SCHOOL DISTRICT
PRESCRIPTION MEDICATION AUTHORIZATION FORM**

The New Hampshire State Board of Education and Lempster Community School Policy require that the following must be completed before any prescription medication will be dispensed:

1. A written Doctors order which includes this form
2. A written authorization from parent or guardian indicating the desire that the school assist the student in matters set forth in the doctor's order, accompanied by a hold harmless release, and signed by the parent/guardian
3. The medication must be in its original container, labeled by a Pharmacist with the student's name, physician's name, date of original prescription, name and strength of medication, and directions for use
4. Only a 30 day supply of medication at one time

ALL PRESCRIPTION MEDICATIONS MUST BE BROUGHT TO THE NURSE'S OFFICE BY A PARENT/GUARDIAN. STUDENTS CANNOT CARRY MEDICATIONS.

PROVIDER'S SECTION

Name of student: _____ DOB: _____ School year : _____

Medication (separate form for each medication) _____

Diagnosis/reason for medication: _____ Dosage/Route: _____

Frequency/time of administration: _____ Recommendations: _____

Side Effects/Restrictions: yes ___ no ___ Yes, please describe: _____

Provider's full name (please print) _____ Phone # _____

PROVIDER'S SIGNATURE _____ **DATE** _____

EMERGENCY MEDICATIONS & INHALERS ONLY: By signing below I am stating that, in my opinion, this student is responsible enough to carry the above medication and self-administer it while at school. A written action plan will accompany this order.;

PROVIDER SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SECTION

I hereby request and give permission for the school nurse, principal or authorized personnel to assist my child in taking the medication listed above during the school day, according to the provider's instructions given above. I agree to hold harmless the Lempster School District and staff from responsibility for any adverse effects that may occur as a result of my child taking the above stated medication or if my child refuses this medication.

Parent/Guardian's full name _____ Phone# _____

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____