Winnisquam Regional School District

Winnisquam Regional High School

435 West Main Street

Tilton, NH 03276

fax 286-2006

Prescription Medication Administration Form

The New Hampshire Board of Education policy regarding the taking of medication in school states, any student who needs to take medication during the school day shall be assisted by the school nurse, principal or other designee only after receiving and filing in the student's health record the following:

1. A written statement from the **licensed prescriber** detailing the method of taking the medication, dosage, and the time schedule of the medication.
2. A written authorization from the **parent/guardian** indicating the desire that the school assist the student in taking the prescribed medication.
3. All medication should be delivered to appropriate school personnel by the **parent/guardian.** All prescription medication must be delivered and contained in its **original** pharmacy container.
4. If your child will be carrying his/her **inhaler or epi-pen** while at school **both** the student's **parent/guardian and physician** must authorize such self-possession and self-administration.

Parent/Guardian please complete the following information:

Student_______________________________________Date of Birth______________

School Year_________________Diagnosis/Condition__________________________

Medication __________________ Route and time of administration ____________

I the parent/guardian of ___________________________by signing this "Hold Harmless" statement, will hold harmless any member of the school staff, who is so designated to assist my child while taking this/these prescribed medications in school.

Signature of Parent/Guardian______________________________Date___________

DELAYED SCHOOL DAY INSTRUCTIONS

In the event that the school day is delayed, your child's morning medication dose should be given at home at the usual time. If your child receives a

9:00am dose at school, you should give this to them at home in order for us to keep the schedule consistent.

It is the responsibility of the parent/guardian to notify the School Nurse if you would prefer other arrangements.

__________Yes, I agree with the above.

OR

_______I would like other arrangements, as stated below:

____
____
____
____

Signature of
Parent/Guardian___________________________________Date______________

Physician to complete and sign the following section:

Medication 1.________________________Dose:__________Frequency:_______

Route of Administration:____________ Time(s) to be given at school__________

Date(s) to be given (if not the entire school year)__________________________

Medication 2.______________________Dose:__________Frequency:_______

Route of Administration:____________Time(s) to be given at school__________

Date to be given (if not the entire school year)____________________________

Medication 3.______________________Dose:__________Frequency:_______

Route of Administration:____________Time(s) to be given at school__________

Date to be given (if not the entire school year)____________________________

Student allowed to carry and self administer metered dose inhaler for asthma control (circle one if indicated) YES NO

Student allowed to carry and self administer an Epi-Pen as prescribed for allergic reaction (circle one if indicated) YES NO

Physician Signature_______________________________Date________________

This can be faxed to 286-2006