SCHOOL ADMINISTRATIVE DISTRICT #59

MEDICATION PERMISSION FORM

This form is to be filled out when it becomes necessary for a student to receive medications during school hours.
Please adhere to the following guidelines:

1. Whenever possible, the time of the medication administration (prescribed and over the counter) should be altered to allow students to receive all doses at home,
2. All medication that is kept in the school can be taken only under the supervision of school personnel.
3. Medication brought to school must be in a container labeled by a pharmacist or physician (MSAD #59 retains the right to refuse any or all requests for administration of medication, namely, improperly labeled medication and/or lack of parental authorization.
4. All medication will need to be picked up by a parent/guardian at the end of the school year. Any medication left at school at the end of the school year will be disposed of.

STUDENT NAME:_____

SCHOOL:_____

NAME OF MEDICATION:_____

DOSE:_____ TIME:_____

REASON FOR MEDICATION:_____

SIDE EFFECTS:_____

I certify that the medication listed below is necessary to this child's health and must be taken during school hours.

Physician
Signature:_____

Printed Physician Name:_____

Date:_____

I give my permission for school personnel to supervise and/or administer the above medication to my child. I also give permission for the school nurse and my child's health care provider to communicate in regards to the above name medication.

Parent/Guardian:_____
_____