Medication Order and Permission Form Requiring HCP Order

Lincoln Akerman School
8 Exeter Rd
Hampton Falls, NH 03844
PH: 603-926-2539 FAX: 603-929-3708

Student Name:_____ **Date of Birth**: _____
is required to take the following medication during the school day (**must be completed by the prescriber OR attach order**):
Diagnosis:

_____

Medication, dose, route, frequency: _____

_____

Start date: _____ **End Date:** _____

Specific instructions for administration and possible side effects:

_____

Allergies:

_____

Other medications student is taking:

_____

Healthcare Provider

Name_____Signature_____Date_____Phone_____

* An attached paper prescription from the healthcare provider is an acceptable substitute to a provider signature on this form.

Parent/Guardian

___ Yes ___ No I give permission for the school nurse to communicate with the provider regarding this medication and treatment if needed, including sending and receiving this form directly from and to Lincoln Akerman School. Parent/Guardian initials ____

All prescription medications must be accompanied by a written order from the prescriber. The responsible adult will deliver the medicine to the school nurse in a pharmacy labeled container listing the student's name, the physician's name, the name of the medicine and the instructions. Not more than a 30-day supply will be accepted. The nurse upon receipt will count all medication. Medications prescribed three or less times per day should be given at home. Over the counter medication may be given, if needed, with the written request of the parent/guardian. If the medication is not available through the Health Office, it must be delivered by the responsible adult in its original container. Dosages given will never exceed label directions without a prescribing order.

I, the parent/guardian, authorize the school nurse or any other member of the school staff so designated by the building principal and trained to assist my child in taking the above medication. I agree that I shall not hold liable any member of the school staff who is directed to assist my child in taking said medication. I consent to communication between the prescribing healthcare provider or clinic and the school nurse necessary for related health care management and the administration of this medicine.

Name_____Signature_____Date_____Phone_____

Record of medication drop off and returns

Date	# dropped off	# picked up	Parent/guard sig	Nurse initials

TO BE COMPLETED BY STAFF WHO ARE ADMINISTERING MEDICATION ON OVERNIGHT FIELD TRIPS

Student Name: DOB:

Medication Dose: Frequency: Route:

Date	Time	Administered by (initials)	Notes

Staff Name	Signature	Initials