Kennett High School
Nursing Office
409 Eagles Way
North Conway, NH 03860
Phone: (603) 356-4350 Fax: (603) 356-4394 or (603) 356-4391

Permission for Medication Administration in School

Grade: _____
Name of Student : _____Date of Birth:_____

To Be Completed by Health Care Provider:
Diagnosis: _____
_____

Medication(s) Prescribed: (generic or brand name)
_____
_____

Dosage, Route, Times of Administration, Duration of Treatment:
_____
_____

Side Effects to be Noted:
_____
_____

Current list of medications:
_____
_____

Student has demonstrated proper administration and has permission to self-carry their asthma inhaler and/or Epipen: YES NO
Please provide a copy of student's Asthma Action and/or Allergy Plan if applicable

_____ _____
MD/NP Name (Printed) MD/NP Signature

_____ _____
Provider Phone Number Date

Parent/Guardian Authorization

I hereby authorize the school nurse or designated staff person to administer the above medication(s) as directed. I further agree that I will not hold liable any member of the school staff and/or individual in an official capacity designated by the School Administration to assist my child in taking the medication noted above.

☐ **Parent/Guardian indicate amount provided to the nursing office: _____**

_____ _____
Parent / Guardian Name (Printed) Parent / Guardian Signature

_____ _____
Emergency Phone Number Date

Date Received at nursing office: _____ RN Signature:_____