Grantham Village School
Phone 603-863-1681 Fax: 603-863-8377
Prescription Permission Form

Date: _____

To: Anne Carey, MSN Ed, BSN, RN, GVS School Nurse

From: _____
(Name of Physician)

Re: _____ DOB:_____
(Name of Student)

This letter is written to request that this student be given medication at school by the school nurse or designee of the Principal.

Medication: _____ Dose: _____

Frequency: _____ From: _____ To: _____

Diagnosis: _____

Potential Side Effects: _____

Physician Signature: _____

I/we, the parent(s) or guardian(s), authorize the school nurse or staff member, so designated by the building Principal, to *assist our child in taking the above medication. I/we will indemnify and hold harmless any member so designated to give this medication.

Parent/Guardian Signature: _____

School Nurse Signature: _____

Date: _____

This medication should be delivered to the school nurse, principal, or the school front office. It should be in the original container, properly labeled (pharmacy label if prescription medication), with the student's name, physician's name, name of medication, and the instructions.
***assist means having the required medication available to the child as needed and observing the child as he/she takes the medication.**

Medication picked up by_____ on_____