School District of New London

DISTRICT ADMINISTRATION OFFICE
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EQUAL OPPORTUNITIES IN EMPLOYMENT - CURRICULUM - ACTIVITIES

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ADMINISTRATION OF MEDICATION CONSENT

** A separate form is needed for each medication and a new form is required annually.

Student Name: _____ **Grade:** _____ **D.O.B.:** _____

School: ☐Parkview ☐Readfield ☐Lincoln ☐Sugar Bush ☐Intermediate/Middle School ☐High School ☐NGA ☐Catalyst

Medication Name: _____ ☐Prescription ☐Non-Prescription

Dosage: _____ **Route:** _____ **Time:** _____

Starting Date: _____ **Termination Date:** _____

Reason for Medication: _____

If "as necessary," conditions under which medication should be given: _____

Precautions, possible unfavorable reactions, and/or interventions: _____

Prescribing Health Care Provider Name (please print):_____**Phone:** _____

Doctors Fax # : _____

Health Care Provider Signature: _____
(Health Care Provider signature is required annually for all prescription medications)

I hereby give my permission for designated school personnel to give this medication to my child according to the directions stated above and for the school nurse to contact my child's physician if necessary.

A physician's written, signed statement and pharmacy-labeled container must be supplied by the parent/guardian if prescribed medicine is to be given during the school day. Over-the-counter medication must be provided to school personnel in its original container.

I further agree to hold the School District of New London and above persons harmless in any and all claims arising from the administration of this medication, according to policy, at school. I agree to notify the school in writing when any change in the above orders is necessary.

Home Phone: ( ) _____ **Cell Phone: ( )** _____ **Work Phone:( )**_____

Signature of Parent:_____ **Date:** _____