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.

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

School: __Parkview __Readfield __Lincoln __Sugar Bush __Intermediate/Middle School __High School

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 Physician Name (please print): _____ **Phone:** _____

Physician Signature: _____

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.

Date: _____ **Home Phone:** _____

Signature of Parent: _____ **Work Phone:** _____