GOFFSTOWN SCHOOL DISTRICT
SCHOOL YEAR _____

PERMISSION TO ADMINISTER A PRESCRIPTION MEDICATION AT SCHOOL
This form must be updated yearly

STUDENT'S NAME _____Grade/Team/Graduation year_____

TEACHER'S NAME (if applicable)_____

MEDICATION NAME_____

DOSAGE _____

TIME OF ADMINISTRATION _____

SPECIAL INSTRUCTIONS _____

_____

MEDICAL REASON FOR MEDICATION _____

_____

SIGNATURE OF PHYSICIAN_____ Date_____

EMERGENCY NUMBERS
1. Name_____
   Phone_____
2. Name_____
   Phone_____

*** ALL MEDICATION MUST BE IN THE ORIGINAL BOTTLE***
**** ADULTS (18 OR OVER) NEED TO BRING MEDS TO THE SCHOOL****
***** IF THIS MEDICATION IS AN INHALER OR AN EPI-PEN, THE STUDENT IS ALLOWED TO SELF-CARRY WITH AN M.D. ORDER (MVMS AND GHS ONLY)*****

I hereby authorize the designated school staff person to administer the above prescribed medication according to the directions. I agree, by signing this statement that I will not hold liable SAU 19, the school nurse, or any other designated staff member for following the directions of above physician's order.

SIGNATURE_____DATE_____

I hereby authorize that, if necessary, the school nurse and above physician may share information relative to the health of _____(student name)

SIGNATURE_____DATE_____

***Both Physician and Parent signatures are required by NH state law.**