SAU#39 Amherst, NH

Clark Elementary	Wilkins Elementary	Mont Vernon	Amherst Middle	Souhegan High
673-2343	673-4411	673-5141	673-8944	673-9940

Medication Authorization/Administration Form

Routine Daily Medications

All prescription medications require written authorization from BOTH a primary care provider (physician, nurse practitioner, physician's assistant) and parent or guardian. Written authorization from a parent or guardian must be provided for any over-the-counter medication. Over-the-counter medications (including homeopathic) prescribed under any of the following conditions require a primary care provider and parent signature:

1. Over-the-counter medications prescribed for treatment of a chronic condition (migraines, allergies, Cystic Fibrosis, Diabetes, Lactose Intolerance, and Gastrointestinal Disorders).
2. Asthma inhalers and emergency use EpiPens or Anakits for known allergies must be accompanied by doctor's order to carry and self-administer or can be secured in Nurse's Office.
3. Prescribed to be dispensed other than by the package directions.

School Year: 20__ - 20__

Physician Section

Student's Full Name:____Teacher/Grade:__________________

Diagnosis/Reason for Medication:____

Medication Name:____Dosage:_________________________

Frequency/Time:____Duration/Expiration Date:________________

(All orders automatically expire at the end of the school year unless earlier date is indicated.)

Side Effects/Restrictions: Yes ______________________________________**None anticipated**:_____________________

Prescribing Healthcare Provider's Full Name: _____________________________________**Date:** ___________________

Telephone Orders

Prescribing Healthcare Provider's Full Name: _____________________________________ **Date:** ___________________

RN Signature: ____**Time:** ___________________

Prescription Label

Pharmacy:	Phone:	RX#:	RX Fill Date:
Pharmacy:	Phone:	RX#:	RX Fill Date:

Parent/Guardian Section

Medication cannot be given unless this section is signed by the parent/guardian.

I hereby give permission for the school nurse to administer or for principal authorized personnel to assist my child, ___________________________, in taking the medication listed above on this form during the school day, according to physician's instructions given above. I agree to hold harmless the Amherst School District from any responsibility for any harmful side effects that may occur as a result of my child taking the above stated medication.

Parent/Guardian Signature: ____Date: ________________