PRESCRIPTION MEDICATION ADMINISTRATION AUTHORIZATION FORM
Prescriptions including: EPI-Pen (self-administered) and Inhaled Medication (self-administered)

Student's Name _____DOB_____

Who lives with parent/guardian at_____

In Nashua, New Hampshire 0306__

Teacher/Advisor_____School_____Grade_____

Name of Medication _____

TO BE PROVIDED BY HEALTH CARE PROVIDER:

_____Diagnosis/Condition

_____Dose, Route other Administration Instructions

_____Frequency & Time(s) to be given at school

_____Dates to be given:_____20___/20___school year

PARENT/GUARDIAN AUTHORIZATION

PLEASE LIST ALL MEDICATION THE CHILD IS TAKING AT HOME (Prescription and over the counter medications) if not a violation of confidentiality.

1. _____
2. _____
3. _____
4. _____

HOLD HARMLESS: I hereby authorize the designated staff person or school nurse to administer the above medication as directed. In consideration for this service, I further agree that I will not hold liable, and will otherwise save harmless, the District and/or any department or employee thereof for death or injury resulting from administration or assistance in the administration of the medication described above. I understand that (a) not more than one month of prescribed medicine may be stored in school, (b) medication will be delivered directly to the School Nurse, Principal or designated staff member by the parent or guardian, if possible, and (c) the medication will be delivered in a container properly labeled with the student's name, the physician's name, the date of original prescription, name and strength of medication and directions for taking by the student.

Printed Name of parent/guardian_____

Signature of parent/guardian_____Date_____

Yes No I give my permission for release/exchange of pertinent information by telephone, mail or electronic exchange including fax or email between the school nurse and the physician's office regarding the above medication.*

Yes No I give my permission for other school personnel to be notified of the medication and any adverse effects.*

**NOTE*: Included in the annual NSD Health History form

Signature of parent/guardian_____Date_____