SCHOOL MEDICATION AUTHORIZATION FORM

Name of Child:

Date of birth:

School Phone: 207-655-1000 FAX # 207-655-1009

Maine State Law allows the school nurse or other designated school personnel to assist students who are required to take medication during the school day. This service is provided to enable the student to remain in school or maintain or improve the potential for education and learning.

Prescription medication ***must be in the container in which it was purchased with a pharmacy label attached.***

Students who have inhalers: IF the student has been instructed by physician in self-administration and may carry the inhaler with them. **Please notify school personnel if this is the case.**

IF the student has been instructed by physician in self-administration an Epi-Pen may be carried with them and self-administered. **Please notify school personnel if this is the case.**

OVER THE COUNTER MEDICATION:

Acetometaphine *(Tylenol)*	Ibuprophen *(Advil)*	Naxproxin *(Aleve)*
Tums	Cough Drops	Chapstick
Immodium	Omaprezole	

Other: _____

I, _____, grant permission for my child,

_____, to have the over the counter medications ***circled***

above to be administered an appropriate dose for age and size, on an as needed basis.

____ *I wish to be notified if my child is administered OTC medication at school.*

____ *I do not wish to be notified if my child is administered OTC medication at school.*

_____ _____

Signature *Date:*

_____

Relationship to the child

Prescription Medications

It is necessary for this medication to be taken during the school day at the time(s) indicated above.

Print Name of Licensed Physician: _____
Signature of Licensed Physician: _____

Address: _____ Phone: _____
Date: _____ License #: _____

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TO BE COMPLETED BY PARENT BEFORE GIVING FORM TO DOCTOR

I request that my child, _____ , be assisted in taking the above prescribed medication at school by authorized persons. I will comply with the school's policies and procedures. I will notify the school if there are changes in my child's health status, changes in medication or change in health care provider.

I authorize exchange of information between my child's Physician, District Nurse, or site administrator with regard to this medication request.

Parent/Guardian Signature: _____

Signature Date: _____ Phone (home): _____

Phone (emergency): _____

Time to be given at school: _____ (please provide one hour range)

Name of medication to be given at school (please provide 1 form for each prescription):

_____

Revised 11/2017