Contoocook Valley School District Medication Administration Form

Student's Name _____ DOB _____

Teacher/Advisor _____Grade _____

Name of Medication _____

To Be Completed by Health Care Provider:

Diagnosis/Condition _____

Dose & Route_____

Frequency & Time(s) to be given at school _____

Dates to be given **_____ school year_** or _____

Optional:
If an AM dose is given at home and is omitted, a dose of _____mg may be given at school after omission is verified by a parent/guardian. School dose may then be given _____ hours later.

Adverse effects/Contraindications _____

_____

Add'l information_____

Licensed Prescriber Signature_____Date_____

Licensed Prescriber's Printed Name_____

Licensed Presriber Telephone Number _____

PARENT/GUARDIAN AUTHORIZATION

PLEASE LIST ALL MEDICATION CHILD IS TAKING AT HOME (Prescription and over the counter medications) if not a violation of confidentiality
1._____ 2. _____

3. _____4._____

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 Contoocook Valley School 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.

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 e-mail 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.

Signature of parent/guardian_____Date_____

8-19-11