Union 69

Hope Elementary/Appleton Village/Lincolnville Central School

Authorization to Administer Medication

Student Name: _____ DOB: _____

Grade: _____ Homeroom Teacher: _____

I am aware that a registered nurse may not be available in the school at all times. Should the school nurse not be available, I understand that there will be a non-medical school employee available who has been properly trained to administer medication to students as directed in the Maine School Health Manual.

*I give permission for the specified medication to be be administered as directed by the physician by either the school nurse or by a trained school employee.

*I give permission to the school nurse to contact the prescribing physician to obtain and provide information about the medication and administration schedule.

*I will deliver the medication to the school in the original prescription container.

*I am aware medication of any classification will not be given without a physician order.

Parent/Guardian Signature: _____

Print Name: _____ Date: _____

Phone (H): _____ (W)_____ (C)_____

TO BE COMPLETED BY PHYSICIAN

Medication: _____Dose: _____

Frequency: _____ Administration Time: _____

Reason for Medication: _____

Side Effects: _____

Special Instructions: _____

_____

Known Allergies: _____

Physician Signature: _____ Date: _____