

GOFFSTOWN HIGH SCHOOL SAU 19

ADMINISTRATION OF PRESCRIPTION MEDICATION AT SCHOOL

New Hampshire State board of Education Policy concerning the taking of medication in school requires that the following steps be completed before any medications be given during school hours:

1. A written doctor’s order which includes the name of the medication, dosage, and time to be given. Plus the length of time the child is to be on the medication.
2. “Authorization for Prescribed Medication during the School Day”, signed by the parent or guardian.
3. The medication, **enough for 1 month** (supplied in the original prescription bottle) **must** be brought to school by a parent or another responsible adult.

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I hereby instruct the designated member of the school staff to assist *
 _____ in taking _____
 (student’s name) (Dosage)
 of _____ at _____ (before or after a meal?)
 (Name of medication) (Time)
 For _____ for _____.
 (Number of days) (Condition being treated)

*This includes field trips.
 Student should keep inhaler with him/her or at the Health Office.
 (Circle one if above medication is an inhaler).

SIGNATURE OF PHYSICIAN **DATE**

AUTHORIZATION FOR PRESCRIBED MEDICATION DURING SCHOOL

I, the parent or guardian, request that my child _____ be allowed to follow the directions of the physician as indicated above. I agree, by signing this statement, that I will not hold liable SAU 19, the School Nurse, or any member of the school staff who is directed to oversee my child in taking his/her medication or following these directions. **I do I do not want the medication given on a field trip. (CIRCLE ONE).**

SIGNATURE OF PARENT OR GUARDIAN **DATE**

 (OPTIONAL RELEASE – SIGNATURE REQUIRED)

I hereby authorize that, if necessary, the school nurse and above physician may share information relative to the health of my child _____.
 Parent signature: _____ date: _____