Authorization For Medication To Be Taken During School Hours

The following section is to be completed by the PARENT/GUARDIAN

School Name_____ Grade _____

Child's Name_____ Sex ____ Birthdate _____
Last First Middle

_____
Physician's Name Address Telephone #

I am aware that RSU #40 School District does not have a Registered Nurse at each school. My child is in need of this medication during school hours to maintain his or her health. I believe his or her need for this medication is so important that it must be given whether or not the School Nurse is present in the building. I request that my child be assisted in taking the medicine described below at school by authorized persons, or be permitted to self-medicate her/himself as also authorized by me and my physician. In addition, I allow the School Nurse to be in contact with my child's physician as needed.

_____ _____ _____ _____
Date Parent/Guardian Signature Home Phone # Emergency #

The following section is to be completed by the PHYSICIAN

DIAGNOSIS FOR WHICH MEDICATION IS GIVEN: _____

Name of medication: _____

Form: _____ Dose: _____

If medicine to be given **DAILY**, at what time? _____

If medicine to be given "**WHEN NEEDED**", describe indications: _____

_____

How soon can it be repeated? _____

Is child authorized to self-medicate her/himself? _____

List significant side effects: _____

Length of time this treatment is recommended: _____

Other information: _____

Allergies to medications: _____

Date _____

PLEASE RETURN FORM TO:
RSU 40 SCHOOL HEALTH SERVICES
PO Box 701
Union, Maine 04862
(207) 785-2277 Ext 224
Fax (207) 785-3124

Physician's Signature: _____