

MEDICATION ORDER FORM

Ellis School, SAU 83, Fremont, NH 03044

(to be completed and returned to the Ellis School's Nursing Office)

New Hampshire State Board of Education Policy requires a written order from a licensed prescriber (Physician, Nurse Practitioner, Dentist, etc.) for a school nurse to administer medications.

This form is to be completed by a licensed prescriber for ALL prescription medications to be administered during school hours. This form must be completed for EACH medication to be dispensed by the school nurse.

This form must also be signed by the parent/guardian authorizing for medication administration.

ALL medications must be brought to the nursing office
in their original container clearly labeled.

PHYSICIAN'S STATEMENT

Designation of administration of the following medication by School Nurse:

Student: _____ Date of Birth: _____

Allergies: _____ No Known Allergies

Diagnosis: _____

Medication: _____

Dose: _____ Route: _____ Frequency: _____

Physician's Name (Please Print): _____

Physician's Signature: _____ Date: _____

PARENT'S STATEMENT

I, the parent/guardian, request that my child, _____, be administered or assisted in taking his/her prescribed medication during school hours. I agree that I will not hold liable the Ellis School district, the School Nurse, or any designee of the school nurse to assist my child in taking his/her medication. I further agree that the School Nurse or Designee may contact the prescribing physician to discuss the effectiveness or adverse responses to the above medication at their discretion.

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____ Date: _____