

Lincoln Street School
25 Lincoln Street
Exeter, New Hampshire 03833
Telephone (603) 775-8860
Fax (603) 775-8968
www.saul6.org

Mary P. Manin, RN, BS
School Nurse

PERMISSION FOR SELF-ADMINISTRATION OF MEDICATIONS IN SCHOOL

My child, _____ is required by Doctor _____,
The prescribing physician, to take the following medication during school hours:

Name of Medication: _____ Dosage: _____

Frequency: _____ Method of taking medication: _____

Reason for taking medication: _____

Other medication student is taking at this
time: _____

In the event of a medication emergency, please list persons to be notified, *other* than parents and
physician: _____

Doctor's phone # _____ Parent(s) phone# _____

Other emergency numbers _____

Prescription medications must be accompanied by the 'Physician's Request for Students possession and Self Administration' form. The medication must be in its original container with the prescription label.

The medicine and necessary paperwork will be delivered to the school nurse and, after approval, the student will be able to carry and self-administer the above medication for any school sponsored activity, event or program.

I, the parent(s)/guardian(s) of _____, authorize our child to self-administer the above medication. They have been instructed in the use and administration, and have read the physician's orders. They have also been instructed to keep the medication on their person and NOT allow any other person to use this medication. Upon using this medication, my child will report directly to the Nurse's Office.

I, the parent(s)/guardian(s) agree by signing this request form and the 'Hold Harmless' statement that follows: I agree that I will not hold liable any member of the school staff who is directed by me to allow my child in self-administering the above stated medication.

Parent(s)/Guardian(s) Printed Name: _____

Parent(s)/Guardian(s) Signature: _____ Date: _____

Student Signature: _____ Date: _____

School Nurse's Signature: _____ Date: _____