RSU #10
PERMISSION TO ADMINISTER MEDICATION IN SCHOOL
GRADES PK-12

Name of Student: _____ School Year: _____
Grade: _____ Teacher: _____

Name of Medication: _____ Dosage: _____ Time: _____

Start date: _____ Stop date: _____

For episodic/emergency events only: Yes No (please circle)

Do we medicate on early release days? Yes No (please circle)

Doctor's Name: _____ Telephone Number: _____

Any possible side effects to be aware of and action to be taken:

_____

_____

Special storage requirements (please check) None____ Refrigerate____ Other_____

NOTE

1. **Students should be medicated at home rather than at school whenever possible.**
2. **All medication will be kept in the school office and can be taken only under the supervision of school personnel with the exception of inhalers, EpiPens, Benadry, Insulin, and or Insulin pumps, and Glucagon.**

I give permission for (name of student)_____ to receive the above medication at school according to standard school policy.

Signature of Parent/Guardian: _____ Date: _____
Signature of School Nurse: _____ Date: _____

Date	Medication	Quanity	Time	Staff Initial

COPY OF PHYSICIAN ORDER ATTACHED IF APPLICABLE