SCHOOL:

LITCHFIELD SCHOOL DISTRICT
SAU #27 – LITCHFIELD, NH 03052

Griffin Memorial School	**Litchfield Middle School**	**Campbell High School**
229 Charles Bancroft Highway	19 McElwain Drive	1 Highlander Court
603-424-5931	603-424-2133	603-546-0300

AUTHORIZATION TO ADMINISTER MEDICATION AT SCHOOL

According to New Hampshire State regulations, medications cannot be administered to students at school without written permission from a physician and from the parents/guardians. This regulation also includes over-the-counter (non-prescription) medications; i.e. Tylenol, Advil, and cold preparations. A new authorization to administer medications form must be completed each school year.

Parents must complete and sign Section A. Physicians must complete and sign Section B.
The completed, signed form and appropriate medications in their original pharmacy containers must be returned to the Nurse's office by an adult. ***Note: Not more than one month of prescribed medicine may be stored in school.***

PARENTAL CONSENT FORM – SECTION A

Student Name:**_______________________________** ***School:*** **______________** ***Grade:*****________**

I authorize the School Nurse, designated administrator or staff member, to administer the medication(s) described below to our child in the manner and dosage specifically stated by the physician. The medication must be delivered directly to the School Nurse, Principal or designated staff member by the parent or guardian, if possible, **in the original pharmacy label.**

Field trip medications must be provided to the nurse in a single dose, pharmacy labeled container prior to the field trip day.

I agree that by signing this request and "Hold Harmless" statement that I shall not hold liable any member of the school staff who is directed by me to assist my child in taking said medication. Please feel free to contact the nurse at your child's school if you have any questions or concerns.

____ __________________________ ______________

Signature Parent or Legal Guardian *Print Name* *Date*

PHYSICIAN'S ORDER(S) – SECTION B

The following medication(s) has been prescribed for ___________________________ and should be given in the exact manner prescribed.

Medication	Diagnosis	Dosage	Route	Time
_____________________	________________________	________________	_________	_____
_____________________	________________________	________________	_________	_____

Side effects may include: ____

Restrictions of Physical Activity (if any) ____

Allergies: ____

Permission to carry (inhaler/epi-pens): ____

Physician's signature*:* ____________________________________ *Date:* _____________________

*Physican's name: (please print)*____

Address: ____ Phone: ____________________

This order can only be signed by an MD; Dentist; Nurse Practitioner (NP, FNP, PNP, APRN/PP); Certified Physician's Assistant or a provider with prescriptive practice.

Revised 3/20/19