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 ________________

Physician's Signature: __________________________

PLEASE RETURN FORM TO:

SCHOOL HEALTH SERVICES
RSU 40
320 Manktown Road
Waldoboro, Maine 04572
(207) 832-8109
Fax (207) 832-8256