

LONDONDERRY SCHOOL DISTRICT

Londonderry, New Hampshire 03053

PARENT'S REQUEST FOR GIVING MEDICATION OR TREATMENT

My child, _____, a student in _____ School, requires medication and /or a medical procedure during the school day as prescribed by his/her physician. I hereby authorize the designated staff person to administer the medication/procedure prescribed below according to the directions. In consideration of the service, I (we) further hereby agree that I (we) will not hold liable, and will otherwise hold harmless, the Londonderry School District and any such member of the school staff thereof for any death or injury resulting from the administration or assistance in the administration of the medication/procedure described below.

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

Optional Release-Signature Required

I hereby authorize communication and exchange of information between the school nurse and my child's health care provider pertaining to this medication order.

Parent signature: _____ Date: _____

PHYSICIAN'S STATEMENT

The above named child, _____, requires medication during the school day as follows:

Diagnosis: _____

Medication: _____ Dosage: _____

Time: _____ Frequency/Duration _____

Route of administration: _____

Possible side effects, adverse reactions, contraindications: _____

Other medications the student is currently taking: _____

Identification of medical procedure (explanation and details, i.e., time and duration):

Date: _____ Signed: _____
(Physician)

Physician Telephone # _____ Print Name _____

All medication (over the counter and prescribed) must be in the original pharmacy labeled container and accompanied by this signed form.