Salem School District
38 Geremonty Drive, Salem New Hampshire 03079

School Year __________

PRESCRIPTION MEDICATION ADMINISTRATION REQUEST
School Year _______ (orders must be renewed yearly)

Last Name  First Name  Date of Birth  Grade  Home Room

PARENTAL PERMISSION

Written authorization from the student's parent and physician is required for all prescription medications. Medication will be kept in a locked cabinet in the school health office and will be administered by the school nurse or a member of the school staff designated by the principal. No more than a 30-day supply of medication may be supplied at one time, and all medication must be in a container labeled by the pharmacy. All medications must be transported to school by the parent with this completed form. Any medication that is not picked up within ten days of the close of school will be disposed of.

In making this request, I agree to hold harmless and indemnify any employee or officer of the school district whose duty it is to assist my child in taking _______________. I further agree to hold harmless and indemnify the Salem School District and any employee or officer for any and all losses that may be occasioned as a result of taking this medication, including adverse reactions.

If my child is taking a field trip, this medication

☐ Does not need to be given
☐ Should be given.

______________________________________________  _______/_____/_______
Parent signature  Date

It is strongly recommended that any student with a serious medical condition, or allergy to insect stings, medication or food, wear a medical alert bracelet to facilitate appropriate emergency treatment.

PHYSICIAN'S ORDER

Name __________________________ DOB _____/_____/_____ Diagnosis __________________________

Medication __________________________ Dose __________________________ Time __________________________

Possible serious side effects __________________________________________________________

Restriction of physical activity (if any) ____________________________________________________

Special instructions _________________________________________________________________

Other medication taken by student ______________________________________________________

Inhalers only:  ☐ This student should carry the inhaler and self-administer (Woodbury and High schools only)

☐ Inhaler should be kept at nurses' office and supervised

______________________________________________
Physician's signature

Date _____/_____/_______

Doctor's Stamp Required

Revised 7/02; 12/06