



NORTHERN HIGHLANDS REGIONAL HIGH SCHOOL

Administration of Over-the-Counter and Prescription Medication

by School Personnel

Physician's Stamp

Student's Name: _____

Date of Birth: _____

Medication: _____

AUTHORIZATION

PARENT	PHYSICIAN
<p>I request that my son/daughter, as authorized by our physician, be administered the medication(s) indicated below in accordance with the written doctor's orders. I understand and agree that:</p> <ul style="list-style-type: none"> I will bring the medication to the Nurse's office in a pharmacy labeled container which will be returned to me or destroyed at the end of the school year. This permission is effective for the current school year only. <p>Medication(s) _____</p> <p>_____</p> <p>I acknowledge that the school district shall have no liability for any good faith act or omission consistent with the law which results in any injury arising from the self-administration of medication. I shall indemnify and hold harmless the Board of Education, its officers, employees or agents against any and all claims, suits or causes of action arising out of the self-administration of medication by the my son/daughter.</p> <p>_____ Parent/Guardian</p> <p>_____ Date</p>	<p>Diagnosis: _____</p> <p>_____</p> <p>Medications _____</p> <p>Form (ex. pill) _____</p> <p>Dose _____</p> <p>Must the medication be administered during the school day _____</p> <p>If given daily, what time? _____</p> <p>_____</p> <p>How soon may it be repeated? _____</p> <p>_____</p> <p>Describe indications _____</p> <p>_____</p> <p>Duration of treatment _____</p> <p>_____</p> <p>List significant side effects _____</p> <p>_____</p> <p>Other information regarding the administration of the medication(s) _____</p> <p>_____</p> <p>Is child capable of self-administration of medication? _____</p> <p>Has the child been instructed on the proper use of the medication? _____</p> <p>Would the student be able to attend school if the medication was not administered during school hours? _____</p> <p>_____</p> <p>Is the student physically fit to attend school if the above listed medication(s) is administered at school? _____</p> <p>_____</p> <p>Is the student free of contagious disease? _____</p> <p>_____</p> <p>_____ Physician's Signature</p> <p>_____ Date</p>

School Physician's Signature: _____