

OYSTER RIVER COOPERATIVE SCHOOL DISTRICT

**PARENT'S REQUEST FOR MEDICATION ADMINISTRATION**  
(PLEASE COMPLETE A SEPARATE FORM FOR EACH MEDICATION)

Student's Name \_\_\_\_\_ Grade \_\_\_\_ Teacher \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_ Time(s) \_\_\_\_\_ and \_\_\_\_\_

Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Reason for Medications \_\_\_\_\_

Changes: 1) \_\_\_\_\_ 2) \_\_\_\_\_

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Initials: \_\_\_\_\_

Do you want medication given on field trips? Yes \_\_\_\_ No \_\_\_\_

Do you want your child called out of class if medication is forgotten? Yes \_\_\_\_ No \_\_\_\_

Additional Comments \_\_\_\_\_

**Medication must be properly identified and delivered directly to the school by an adult in order to be safely administered.**

Prescription medication should be accompanied by a written doctor's order and be in an original pharmacy container which identifies student, medication, dosage, time of administration, duration date, and physician's name.

Over the counter medication, in its original container, should be labeled with student's name, time to be administered, and parent written permission.

All student medications are to be kept in the nurse's office. Inhalers, insulin for insulin pumps, and single dose emergency medications may be carried by a student if the student's physician/primary health provider provides a written order stating a medication may be kept with the student in the event of a medical emergency.

I understand that a new request must be filed each school year. By signing this statement, I hereby agree to indemnify and hold harmless The Oyster River Cooperative School District, its agents, and employees from any and all liability as a result of this authorization.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Please Return to your school nurse: FAX #: ORHS=603-868-1355, ORMS=603-868-3469, MOH=603-742-7569, MW=603-659-8612