# School District of Gilmanton

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## SCHOOL MEDICATION/PROCEDURE FORM

### STUDENT INFORMATION:

| Student's Name | Date of Birth | School | School Year/Effective Dates |
|---|---|---|---|
| | | | |

| Medication/Procedure | Dosage | Time/Frequency | Student's Practitioner |
|---|---|---|---|
| | | | |

Reason for Medication/Procedure: _____

Note: For prescription medication ***Signed*** **Parent Consent** and ***Signed*** **Practitioner's Order** required.
For non-prescription medication ***Signed*** **Parent Consent** required.

**PARENT CONSENT:** Complete for **EACH MEDICATION/PROCEDURE** at school. (Please review your school's handbook for specific information regarding the medication policy.)

*I request that this medication/procedure be administered at school.*

*Medication will be supplied in its original, properly labeled container.*

*This order is in effect for this school year unless otherwise indicated.*

*I will notify the school in writing for any changes and obtain a new practitioner's order.*

*I authorize school personnel to exchange information verbally or in writing with my child's practitioner regarding this medication or the condition for which it is prescribed.*

I release the school district from any liability claims as a result of the administration of this medication or procedure as directed.

_____

**Date** **Parent/Guardian Signature** **Telephone #**

**PRACTITIONER'S ORDER:** Complete for **EACH PRESCRIPTION MEDICATION/PROCEDURE** at school. The above medication/procedure is to be administered during the school day in accordance with the above instructions. Please contact me if the following symptoms occur:

_____

_____

Additional information: _____

| | | |
|---|---|---|
| **For Asthma Inhaler – student may carry inhaler at school** | **Yes** | **No** |
| **For Epinephrine Auto Injectors – Student may carry injector at school** | **Yes** | **No** |

_____ _____

**Date** **Practitioner's Signature** **Telephone #**