South Portland School Department Health Services

Authorization to Administer Medication in School

Which Must Be Taken During School Hours

** All medication(s) must be in a clearly labeled container with student's name, prescribed dosage and name of medication. **Prescription medication must be in original prescription container.**
Your pharmacist can provide an additional labeled container for use at school.

Parental requests must be accompanied by a written order from the physician/medical practitioner or dentist, substantiating the fact that the administration of a particular medication during the school day is medically necessary for the pupil's health and attendance in school. Such order shall state any unique administration procedure, if appropriate.

** Parent/guardian must personally provide school with up to one week's dosage unless other arrangements have been made with the school nurse.

Students Name:____School:____________________Grade___

Name of medication:____

Medication description: circle one (capsule, tablet, gel, liquid, drops, inhalants)
If tablet: shape;________________ Markings (letters,#'s):___________________Color________________

Dosage:________________________________ Time to be given:___________________________________

Doctor's Name:____ Doctor's ph #____________________

Reason for medication____

Side effects staff should be aware of____

Termination date (not beyond the current school year)____

Medication Removal

Only a limited, necessary supply of medication(s) can be kept in the school. Parent or legal guardian must remove Medication(s) no longer required. Any medication not removed by the last day of school each year will be destroyed by the nurse in the presence of a witness. Furthermore, it shall be the parent's responsibility to notify the school of any changes or the discontinuation of a prescribed medication that is being administered to the child in school.

Informed Consent of Parent /Legal Guardian

*I hereby request that school department personnel administer the above medication to my child. I am aware that this medication may be administered by medical or non-licensed personnel.

*I give my permission for the school nurse to contact the above named prescribing physician to obtain information about the medication and the administration schedule. I give permission for the school nurse to share information with the doctor about the effects of the medication on my child's learning.

*I understand that information may be shared with appropriate school personnel.

Parent/Legal Guardian Signature____Date: ______________

Home phone #_____________________________________work phone#____________________________

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