

New Boston Central School

*"A Special Place to Learn and Grow"*

15 Central School Road New Boston, NH 03070 (603) 487-2211 FAX (603) 487-2215

**ADMINISTRATION OF MEDICATION IN SCHOOL**

(Please return completed form to the School Nurse at the above address)

New Hampshire State Board of Education Policy concerning the taking of medication in school requires that the following steps be completed before any medication can be given during school hours:

1. A written, signed doctor's order which includes the name of the medication, dosage, and time to be given, as well as the length of time the child is to be on the medication.
2. Parent Request signed by parent or guardian.
3. The medication (in the original, pharmacy-labeled prescription bottle) should be brought to school by the parents.

**Pupil's Name** \_\_\_\_\_

**Medication** \_\_\_\_\_

**Dosage** \_\_\_\_\_

**Method of Taking Medication** \_\_\_\_\_

**Time Schedule to be Observed** \_\_\_\_\_

**Medication to be taken from** \_\_\_\_\_ **to** \_\_\_\_\_  
(Date) (Date)

**Possible Side Effects** \_\_\_\_\_

**May this child self-carry + self administer this medication?** \_\_\_Yes \_\_\_No

**Physician's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parental Request**

I request the nurse or staff member assist my child in taking the prescribed medication. No more than one month supply of medication is to be stored at school. I give my permission to share the above information with the appropriate school staff members.

If the medication I supply expires during the school year, I understand it is my responsibility to provide a replacement prior to the date of expiration. **My child's medication expires on** \_\_\_\_\_

I, the parent or guardian, agree by signing this request and "Hold Harmless" statement, that I shall not hold liable any member of the school staff who is directed by me to assist my child in taking said medication.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Parent or Guardian)