Pelham School District

PARENT'S REQUEST FOR ADMINISTERING *PRESCRIPTION* MEDICATION AT SCHOOL

My child,_____, a student in Pelham School District Grade_____requires medication during the school day as prescribed by his/her physician. I hereby authorize the designated staff person to administer the medication prescribed below according to the directions. In consideration of the service, I (we) further hereby agree that I (we) will not hold liable, and will otherwise hold harmless, the Pelham School District and any such member of the administration of the medication listed below. This includes permission to confer with my child's physician, if necessary.

Date:_____ Signature: _____

Print Name: _____

PHYSICIAN'S STATEMENT

The above named student,_____, requires medication during the school day as follows:

Diagnosis: _____

Medication:_____Dosage: _____

Age of Medication:_____

Time:_____Frequency/Duration: _____

Route of Administration: _____

Possible side effects, adverse reactions, and contraindications:

_____

_____

Other medications the student is currently taking: _____

Physician signature:_____Print Name: _____

Date:_____Physician Telephone #: _____

All medication must be in the original pharmacy labeled container and accompanied by this signed form.

This consent is valid for one school year

Pelham Elementary School Fax# 603-635-8922
Pelham Middle School Fax# 603-635-2369
Pelham High School Fax# 603-635-3994