

Pelham High District  
PELHAM HIGH SCHOOL  
PARENT'S REQUEST FOR GIVING MEDICINE AT SCHOOL

My child, \_\_\_\_\_, a student at Pelham High School in Grade \_\_\_\_\_, requires medication during the school day as prescribed by his/her physician. I hereby request that the School Nurse, or some other staff member designated by the Principal, keep the medicine in his/her custody and assist my child in taking the same in accordance with the physician's directions specified herein and with the requirements of relevant State Board of Education regulations.

In making this request, we, the parents, agree that we will not hold liable the Pelham School District or any member of the school staff whose duty it is to assist our child in taking oral medicine, and further we agree to hold harmless and indemnify the Pelham School District any such member of the school staff for any and all losses which may be occasioned as the result of assisting our child in taking such oral medicine, which are **in the original pharmacy container**. This includes injectable emergency medication. I also give the School Nurse or Principal permission to confer with the physician, if necessary.

1. Identification of Medicine \_\_\_\_\_  
Dosage: \_\_\_\_\_  
Method of Taking: \_\_\_\_\_  
Time Schedule to be observed: \_\_\_\_\_  
Reason for giving Medication: \_\_\_\_\_

2. Identification of Medication: \_\_\_\_\_  
Dosage: \_\_\_\_\_  
Method of Taking: \_\_\_\_\_  
Time Schedule to be observed: \_\_\_\_\_  
Reason for taking Medication: \_\_\_\_\_

This order is effective until \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Parent: \_\_\_\_\_

Telephone # \_\_\_\_\_

Phone: (603) 635-6906

Fax (603) 635-3994

PELHAM SCHOOL DISTRICT  
Pelham New Hampshire 03076  
PELHAM HIGH SCHOOL

PARENT'S REQUEST FOR GIVING MEDICATION OR TREATMENT AT SCHOOL

My child, \_\_\_\_\_, a student in Pelham High School  
Grade \_\_\_\_\_ requires medication and/or a medical procedure during the school day as  
prescribed by his/her physician. I hereby authorize the designated staff person to administer the  
medication/procedure 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/procedure described below. This includes permission to confer with physician, if  
necessary.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

**PHYSICIAN'S STATEMENT**

The above named student, \_\_\_\_\_, requires medication and or a  
medical procedure during the school day as follows:

Diagnosis: \_\_\_\_\_

Mediation: \_\_\_\_\_ Dosage: \_\_\_\_\_

Time: \_\_\_\_\_ Frequency/Duration: \_\_\_\_\_

Route of Administration:

Possible side effects, adverse reactions, and contraindications:

\_\_\_\_\_  
\_\_\_\_\_

Other medications the student is currently taking:

Identification of medical procedure (explanation and details, i.e., time and duration);

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Signed: \_\_\_\_\_

(Physician)

Physician Telephone # \_\_\_\_\_ Print Name \_\_\_\_\_

**All medication (over the counter and prescribed) must be in the original pharmacy labeled  
container and accompanied by this signed form.**

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