

Merrimack Middle School
Parental Permission to Administer Medications

Name of Student: _____ Date of Birth: _____

Student Weight: _____ (OTC meds dose is often determined by weight) Grade: _____

Allergies: _____ Medications Taken at Home: _____

THIS FORM MUST BE RETURNED TO THE HEALTH OFFICE BEFORE ANY MEDICATION WILL BE ADMINISTERED. COMPLETE THE SECTIONS THAT ARE APPLICABLE AND INDICATE N/A ON THOSE THAT ARE NOT APPLICABLE.

Prescription Medications

Before any prescription drugs may be administered to any student, the parent must complete and sign this form **and must also submit the Prescription Authorization Form** completed by student's medical provider.

Over-the-Counter Medications

Below is a list of over-the-counter medications approved by the Merrimack School District. **Please initial the medications** that you will provide and authorize the District to administer to your child as needed.

Parent Initial

Medications approved for administration

Parent Initials

School Provides:

_____ Tums 350-750 mg/tab
_____ Ibuprofen (Motrin, Advil) 200 mg each tablet
_____ Extra Strength Acetaminophen (Tylenol) 500 mg each tablet

Parent Must Provide:

_____ Cold/Allergy Medication
_____ Lactaid
_____ Midol
_____ Excedrin
_____ Diphenhydramine (Benadryl)
_____ Other _____

PROCEDURES FOR ADMINISTRATION OF MEDICATIONS

- A new Parental Permission to Administer Medication form must be completed for each school year and any time there is a change in a student's prescription medication or a change in the approved OTC medications for a student. A new Prescription Authorization form is required if there is any change in the student's prescription medication or dosage.
- The high school health office has acetaminophen, ibuprofen, cough drops, and Tums. All other over-the-counter medications **must** be supplied by the parent to the Health Office and must be in a **small original container**.
- All prescription medications **must** be supplied by the parent to the Health Office and must be in a **small original container containing the student's name and the required dosage**. Parents are responsible for assuring that an adequate supply of the medication is available in the Health Office.
- Any over-the-counter or prescription medications not picked up by the parent by the end of the school year will be disposed of by the District.
- Medication may not be transported by a student and will not be released to a student at any time, other than the dispensing of an authorized dosage.
- Only the School Nurse or other school personnel designated by the School Principal can dispense prescription or over-the-counter medicine to students. If the school nurse is unavailable, or if the student is on a field trip, the school

principal or his/her designee may assist the student in taking required medication(s) by making such medication(s) available as needed; and by observing the student as he/she takes or does not take his/her medication.

- The School Nurse, or other designated school personnel, will determine when it is appropriate to administer the OTC medication(s) identified above. The OTC medication will be dispensed in accordance with the specifications on the medication label, unless a note from a physician specifically authorizing a different dosage has been provided to the Health Office.
- Prescription medications will be administered at the times and in the dosages specified on the **PRESCRIPTION AUTHORIZATION FORM COMPLETED BY THE MEDICAL PROVIDER**.
- Parents are responsible for notifying the school nurse if their child took any medication before school.
- Homeopathic/herbs medication will not be administered in the school setting.
- Please refer to the Merrimack School Board Policy; *Administering Medication to Students*

PARENTAL CONSENT TO ADMINISTER OVER-THE-COUNTER AND PRESCRIPTION MEDICATION

I have read and understand the above Procedures and the attached Merrimack School Board Policy. I authorize the Merrimack School District to administer any of the above indicated medications to my child during the school day or during school sponsored trips. I understand that my child must assume responsibility of reporting to the Health Office for the medication. I certify, to the best of my knowledge, that my child does not have an allergy or sensitivity, I will notify the school nurse immediately. This authorization shall take effect on the date listed below and shall stay in effect until I submit a new permission form or revoke permission in writing. I understand that the Merrimack School District does not assume responsibility for the effectiveness or adverse effects of any medications provided hereunder and I hereby release the Merrimack School District, the Merrimack School Board, and its agents and employees from all liability, claims, and causes of action for injuries related to the administration of or failure to administer any medication, except for injuries resulting from the district's intentional misconduct or gross negligence.

Parent Signature: _____ **Date:** _____

The doctor can fill out this form, or you can call and ask them to fax Doctor's Orders and an emergency plan (if required) to: 603-423-1109 Attn: NURSE

Merrimack Middle School
PRESCRIPTION AUTHORIZATION FORM
MEDICAL PROVIDER SECTION FOR ALL PRESCRIPTION
MEDICATIONS (to be completed by the student's medical provider)

Student Name: _____ Date of Birth: _____ Date Prescribed: _____
Medication (s): _____
Duration of RX: _____ Diagnosis/Indications for Administration: _____
Dose: _____ Route: _____ Daily Time of Administration/or PRN: _____
Frequency: _____ If PRN Describe Indication(s) for Administration: _____
Side Effects/Interventions for Adverse Reactions: _____
Other Information: _____

Health Care Provider Signature: _____ Date: _____ Phone: _____
Parental Authorization to Administer Medication _____ Date: _____

AUTHORIZATION FOR SELF-ADMINISTRATION OF MEDICATION
DURING SCHOOL HOURS (Epi-pen, Inhaler, Insulin only)

I have instructed the above student in the use of his/her Epi-pen / Inhaler / Insulin, and he/she may carry the medication on his/her person and self-administer medication as instructed by me and prescribed on the Prescription Authorization Form during school hours.

Health Care Provider Signature _____ Date: _____ Phone: _____

PARENT/GUARDIAN REQUEST FOR SELF-ADMINISTRATION OF EPI-PEN, INHALER or INSULIN

This section must be completed and signed before the student will be permitted to self-administer medication. The Prescription Authorization Form must also be completed by the student's medical provider and must be on file in the Health Office.

All boxes must be initialed:

- _____ I request that my child be permitted to carry and self-administer his/her Epi-pen, Insulin Pump, Insulin, or inhaler at school, as authorized by his/her medical care provider on the Prescription Authorization Form
- _____ I hereby release the Merrimack School District, the Merrimack School Board, and its agent and employees from all liability, claims, and causes of action for injuries resulting from my child's self-administration of medication, including my child's misuse of or failure to administer the medication.
- _____ I accept the responsibility that my child carries the drug at all times.

Parent Signature _____ Date: _____