

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: \_\_\_\_\_