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

Student Name:_____Date Prescribed: Duration of Prescription: _____

Diagnosis/Indications for Administration: _____

Medication(s):_____Dose: Route: _____ Daily Time of Administration/or PRN:_____Frequency: _____

If PRN Describe Indication(s) for Administration: _____

Side Effects/Intervention for Adverse Reactions: _____

Other Information: _____

Attach Asthma Action Plan or Diabetes Plan if it applies to the student

Health Care Provider Signature:_____Date: _____

Contact Number: _____

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

I have instructed the above student in the use of his/her Epi-pen, Insulin, Insulin Pump and/or Inhaler 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: _____

Contact Number: _____

PARENT/GUARDIAN REQUEST FOR SELF-ADMINISTRATION OF EPI-PEN, INSULIN, INSULIN PUMP, AND/OR INHALER

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 accept responsibility for making sure that my child carries the drug at all times.

_____ 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 resulting from my child's self-administration of medication, including my child's misuse of or failure to administer the medication.

Parent Signature:_____Date: _____