Merrimack School District
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 Initials	Medications approved for administration	Parent Initials
_____	Antacids (Rolaids, Tums)	_____ Calamine/Caladryl
_____	Ibuprofen (Motrin, Advil)	_____ Cold/Allergy Medication
_____	Acetaminophen (Tylenol)	_____ Pamprin
_____	Diphenhydramine (Benadryl)	_____ Anbesol
_____	Cough Drops **(NOT** recommended for elementary school age children)	_____ Lactaid
_____	Motion Sickness Medication	_____ Midol
		_____ Bacitracin Ointment

PROCEDURES FOR ADMINISTRATION OF OTC and PRESCRIPTION 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.

- All 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.

- Over-the-counter medications will only be given two hours after the start and before the end of the school day to prevent doubling up on a dose that may be given at home. This is subject to change when deemed necessary by the school nurse (i.e. onset of a migraine headache.)
- 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 and vitamins <u>will not</u> be administered in the school setting**.
- Please refer to the Merrimack School Board Policy; *Administering Medication to Students*, attached hereto.

PARENTAL CONSENT TO ADMINISTER OVER-THE-COUNTER AND/OR 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 Over-the-Counter or prescription 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: _____

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: _____